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BUDGET REQUEST FY87

Department of Public Welfare
Commonwealth of Massachusetts

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Narrative



CHARLES M. ATKINS
Commissioner

The Commonwealth of Massachusetts

*Executive Office of Human Services
Department of Public Welfare
180 Tremont Street, Boston 02111*

TO: Philip W. Johnston, Secretary
Executive Office of Human Services

FROM: Charles M. Atkins, Commissioner
Department of Public Welfare

DATE: January 22, 1986

RE: Implementing Opportunity for All: The Welfare Department's FY87
Budget Request (H.1)

I am pleased to present this FY87 budget narrative as documentation for the best budget request for the Department which any governor has ever submitted to the legislature.

I. Executive Summary

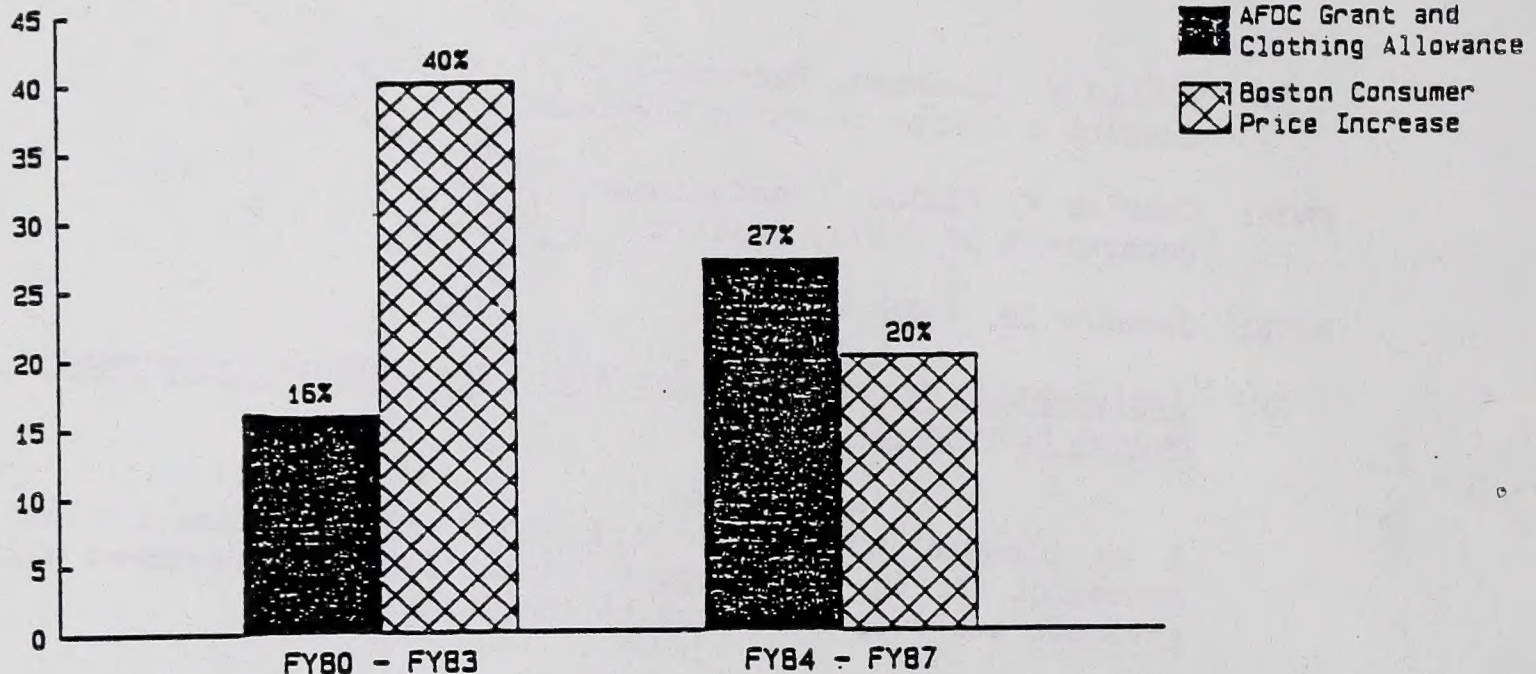
The most important aspects of the Governor's proposal (H.1) are:

- o A route out of poverty through ET for 10,000 more welfare recipients. The FY87 budget request would enable an additional 10,000 clients to join the more than 23,000 AFDC and GR recipients already placed into jobs since the Employment and Training (ET) Choices program began in October of 1983. The average wage for those clients obtaining full-time jobs is now over \$10,000 per year. The AFDC caseload reached a 12-year low last fiscal year as a result of ET and the strong economy. Net savings to the taxpayers (after deducting the costs of ET) are almost \$70 million to date.
- o A 10% increase in AFDC and GR grant levels. This increase, at a cost of \$55 million, is the largest ever proposed by a Massachusetts governor. The importance of the proposed 10% increase can be seen by the following chart, which compares AFDC grant increases over the most recent four fiscal years and the previous four fiscal years with inflation. As this chart shows, from FY80 to FY83 inflation rose 40% and benefits only rose 16% (the erosion in benefit levels was especially severe during

FY80 and FY81 when inflation increased 26% and benefits increased only 12%). By contrast, a 10% CoL will mean that benefits will have risen 27%, compared to an inflation rate of 20% from FY84 to FY87.

AFDC Grant Increases V Inflation FY80 - FY87

Percent Increase



- o A \$70 million increase in the agency's savings and revenue agenda. This raises the agency's total (new and continuing) savings and revenue agenda to a record \$428.5 million, or almost 20% of spending proposed in H.1. These savings result from management initiatives and are in addition to the federal reimbursement the state receives.
- o A limited increase in overall spending. H.1 recommends welfare appropriations totalling \$ 2.214 billion. This spending level is \$118 million or 5.6% above projected FY86 levels, less than the percentage increase for many other state agencies. Further, H.1 proposes that the Department obtain \$947.7 billion in federal reimbursement. This reimbursement reduces the agency's FY87 net state cost to just over \$1 billion and means that the net state cost of the increase proposed for the agency is only \$59 million.

Before describing these and other proposals in detail, I wanted to take this opportunity to renew the agency's performance over the last three years.

II. Agency Performance, 1983-1986

In early 1983, the Welfare Department faced several problems. The agency did not offer clients credible alternatives to remaining in poverty. Indeed, the previous administration's "workfare" program had the effect of discouraging clients from believing they could become self-sufficient. Further, grant levels were declining as a percentage of the poverty line, and the agency's local offices did not consistently provide compassionate responses to client needs.

On the management side, the Department had neither explicit, written priorities, as is the case today, nor an effective system for holding managers accountable for reaching agency goals. The result was that error rates in major Department programs were increasing. Two of the major divisions responsible for producing collections had stopped bringing in new money. The effort to implement a new Medicaid computer system was on the brink of failure -- for the third time. Labor-management relations were poor and worker turnover, especially in the Department's larger offices, was as high as 25%. It also took up to nine months to fill a vacancy with a trained worker. In sum, the Department's record as an antipoverty agency was poor, and its performance on its day-to-day responsibilities was mediocre.

I believe agency performance since 1983 is considerably better. Over the last three years, one of the Department's principal commitments has been to extend opportunity to all the clients we serve through a combination of ET, increased grants, child support, and assistance to the homeless. At the same time, the Department has made a number of significant management improvements, most notably designing and implementing our nationally-known ET program and attaining the lowest error rates in the agency's history. Your support, the committed effort of our employees, and assistance from the legislature and from other agencies in state government, helped make the agency's accomplishments possible. Specific successes in which all of us can take pride in having helped to accomplish include:

AGENCY PERFORMANCE
FY83 v. FY86

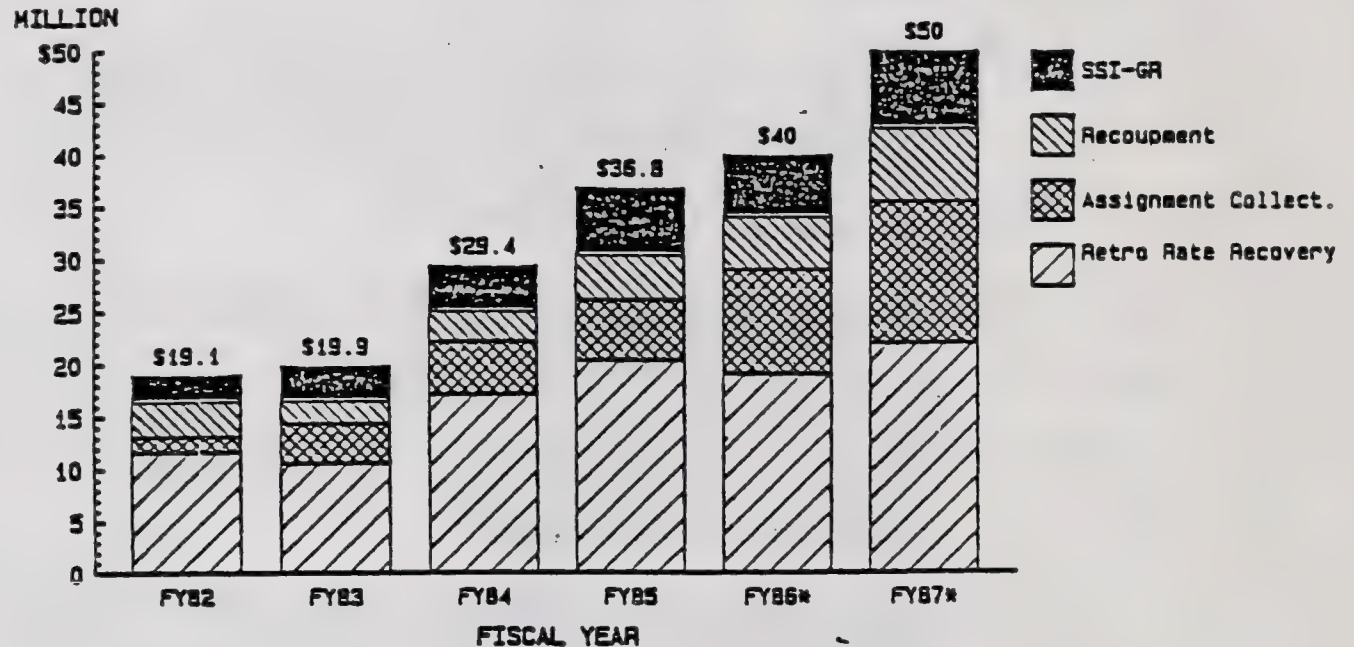
	<u>FY83</u>	<u>FY86 (Projected)</u>
ET placements	N/A	10,000
CoL increase v. inflation	16% CoL v. 40% inflation (FY80-FY83)	16% CoL v 13% inflation (FY84-FY86)
Homeless shelters	2	51
Error rates:		
AFDC	11.6%	3.0%
Medicaid	6.6%	1.2%
Savings and Revenue	\$ 92 million	\$ 358 million
MMIS savings	N/A	\$ 64 million
Child Support Collections	\$ 40 million	\$ 50 million.
Staff Turnover	25 - 30%	10 - 15%
Caseload-to-worker ratios	210:1	170:1
PGH enrollment	44,000	120,000

- A. providing over 23,000 AFDC and GR recipients with jobs as an alternative to continuing to live in poverty through the ET program, which began in October 1983.
- B. increasing assistance to welfare recipients through a 16% increase in AFDC grant and a 30% increase in GR grants-- while inflation was rising only 13% for the 1983 to 1986 period.
- C. assisting the homeless and preventing homelessness. Key elements in providing this help were an increase in the number of Department-funded shelters from only 2 at the start of the Dukakis Administration to 51 in FY86 and a significant expansion in the emergency services the agency can provide our clients -- through a broader AFDC Emergency Assistance (EA) program, the establishment of a General Relief EA program, and restoring the GR medical program.

- D. reducing AFDC and Medicaid error rates to the lowest levels in the agency's history. The current AFDC error rate is 3.0% and the current Medicaid error rate is 1.2%. These error rates are one-third of what they were three years ago, when the AFDC error rate was 11.6% and the Medicaid error rate 6.6%. For the first time in the history of the state, both the AFDC and Medicaid error rates are now at or below the federal sanction level of 3%. This reduction in the two error rates has avoided more than \$40 million in potential error rate sanctions.
- E. despite the investment necessary to make these accomplishments possible, maintaining spending growth in the FY83-86 period at an average of only 5% per year -- roughly the same as the Boston Consumer Price Index for this period and significantly lower than the spending growth rates for the rest of state government.
- F. controlling Medicaid spending, which had grown an average of over 10% annually for the ten year period from FY74 to FY83, to an average of only 6% annually over the past three years. In this same time period, the Department was able to increase by more than 90% -- to 86,000 -- the number of children participating in Project Good Health, our preventive health program.
- G. achieving the largest growth in savings and revenue activities in the agency's history -- from an actual \$92.1 million in FY83 to \$303.4 million in FY85 to a projected \$358 million in FY86. Keys to this growth:
- o establishing the ET program, without which our caseload would have grown to over 93,000 compared to 85,000 today;
 - o the successful implementation of MMIS, our sophisticated Medicaid claims review and payment computer system; and

- o dramatic management improvement in the Finance division (recouping payments to recipients and providers) from \$19 million in FY82 to \$40 million in FY86, and in Child Support (which collected a record \$45 million last fiscal year despite a declining caseload), and in other agency activities.

FINANCE COLLECTIONS FY82-FY87



collected

- H. obtaining \$65 million in new and additional federal revenue -- revenue beyond the 50% federal share of AFDC, Medicaid, and administrative expenses -- through MMIS certification, keeping Medicaid costs below a federal target, and through energetic and creative legal, analytic, and accounting work on a number of other projects for this and other state agencies.
- I. reducing local office staff turnover by 30%, thanks in large measure to support from the administration and the legislature for salary increases and improved space and equipment for local office staff. The reduction in turnover is one sign of the dramatic commitment to excellence on the part of agency local office staff--who were the key to most of the accomplishments listed above.

I look forward to continuing this pattern of strong performance for the balance of FY86 and on into FY87. Major elements of our proposed agenda for FY87 are outlined below.

III. Specific Proposals

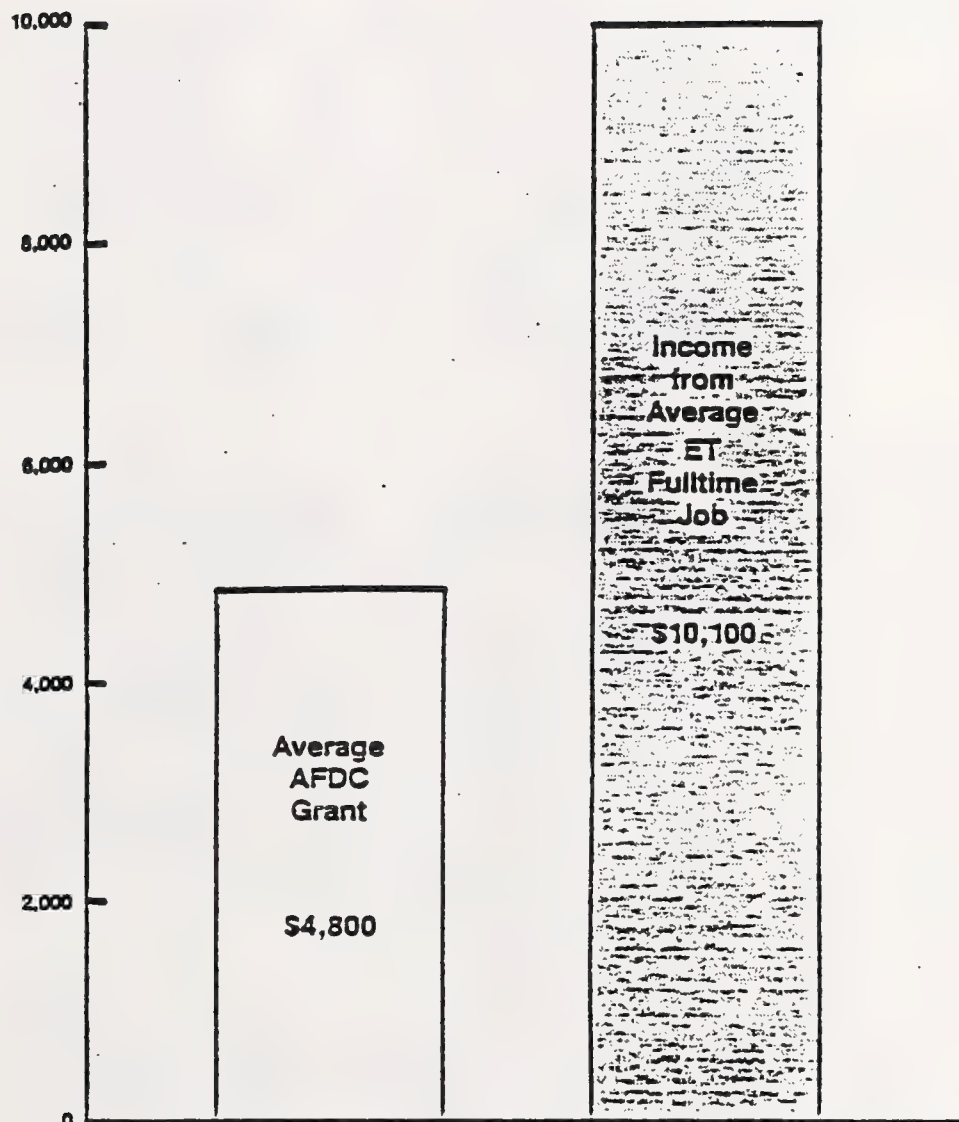
The H.1 request includes the following key proposals:

A. Employment and Training

Through January 1, 1986, the ET program has placed 23,048 clients into full or part-time jobs. Through ET:

- o clients in full time placements make an average of \$5.18 per hour, or \$10,100 per year. As the following chart shows, this is more than twice the income welfare provided to these families.

INCOME: WELFARE VS. WAGES, 1985



- o the AFDC caseload average for FY85 was the lowest in twelve years. Viewed another way, without ET, the November caseload would have been 95,945 -- instead of 85,411, the actual caseload.
- o The taxpayers have saved \$69 million. These are the savings after program costs.

- o the 75,000 people -- two-thirds of whom are children-
- who make up the ET placement households have
excellent prospects for the future. A full 86% of the
families who leave AFDC through ET are still off one
year later.

The H.1 request builds on this performance. The request proposes the funds necessary to continue ET's emphasis on recipient choice among program components which lead to long term employment. The request also includes the support services, especially day care and transportation, necessary to make possible the transition from welfare to work. The request includes funds to provide contractors with an incentive to place clients into jobs with the highest possible wage levels. In addition, H.1 expands ET in two significant ways:

- 1) \$7.1 million for literacy, basic skills and youth programs specifically targeted at clients who need more preparation for work. These harder-to-serve clients include those for whom English is a second language, and those who have been on welfare for several years, have less than a high school education, or have learning disabilities. The H.1 request would also enable expanded services for teenagers who are the children of AFDC parents--and teenagers who have themselves recently become parents. The goal of this expansion is to make sure that these families have the services they need to move out of poverty.
- 2) \$1.4 million for a new program of health coverage for the 25% of ET graduates whose jobs do not include health insurance. This program will make it possible for these families to obtain health insurance at little or no cost for the first year following job placement. Legislative approval of this proposal would mean that AFDC parents thinking about leaving welfare through ET will not have to worry about how they will meet their families' health care costs once they no longer have Medicaid. This will encourage participation in ET and help ET graduates remain off welfare.

B. 10% Grant Increase

ET is our best anti-poverty strategy because of the dramatic and lasting impact it has on the income, prospects, and self-esteem of the clients it places into jobs. However, adequate grant levels are also critically important, for those clients who are not yet able to participate in ET as well as for those who are already participating. The 10% increase proposed in H.1 is a significant step toward grant levels which clients can actually live on. The 10% is especially important because:

- 1) it responds to the dramatic tightening of the housing market. In Boston between 1982 and 1984, 80% of the housing renting for less than \$300 disappeared because rents increased and units were either converted to condominiums or became uninhabitable. Housing prices in Boston rose more than 36% during the last year. Further, the shortage of affordable housing is not limited to Boston, or the private housing market. A recent survey of 17 local housing authorities found that waiting lists average three to five years. Applications and waiting lists even at suburban housing authorities in such locations as Waltham and Newton have increased sharply. At present about 30% of AFDC families live in public or subsidized housing, and the long waiting lists mean that percentage is unlikely to increase.

The 1983 and 1985 housing authorizations which the legislature enacted will provide more low- and moderate-income units. However, for the 85,000 AFDC and 25,000 GR households facing an immediate problem, a 10% grant increase effective July 1 may be the difference between being able to pay a rent increase and being evicted. A 10% increase is worth \$43 per month for the typical AFDC family, and \$24 each month for the typical GR client. The grant increase will also mean that those families which do have to move will have a better chance of finding an apartment.

- 2) an AFDC mother who is worried about making the present grants of \$432 in AFDC and \$152 in Food Stamps stretch to cover a full month's expenses is going to have difficulty thinking about anything other than how to get through the month. She will not be able to put much energy into changing her life for the future by getting a marketable skill and a job through ET. As advocates for the poor have noted, with a program as effective as ET, we can think of AFDC as a stipend for people who are acquiring the skills they need to achieve economic self-sufficiency. If the stipend is too small, the clients will struggle to manage a situation where the cost of basic necessities may exceed income by \$100 or more each month. This makes it much harder for the clients to focus time and energy on getting marketable skills and moving out of poverty through ET. If the 10% grant increase is approved, in 1987, the Commonwealth will be providing AFDC families with \$100 more per month in income than in 1983. This is a substantial investment in improved support for our clients, an investment I believe will pay off in increased client participation in ET.
- 3) as the table below shows, the 10% CoL, together with the other grant or clothing allowance increases in FY84, FY85, and FY86, helps us move toward closing the poverty gap which developed between FY79 and FY84.

BENEFITS FOR AN AFDC
FAMILY OF THREE

	<u>FY79</u>	<u>FY84</u>	<u>FY87 Proposed</u>
Cash Benefits	\$4,049	\$4,556	\$5,712
Clothing Allowance	0	250	250
Food Stamps	1,104	1,776	1,716
Total	<u>\$5,153</u>	<u>\$6,582</u>	<u>\$7,678</u>
Poverty Level	\$5,178*	\$8,200**	\$9,142***
Percent	100%	80%	84%

* 1978 Poverty Level

** Estimated FY84 poverty level

*** 1986 Poverty Level (estimated assuming 3.3% inflation)

C. Critical Client Services

Along with ET and the AFDC and GR cost of living increases, H.1 funds a continuation and expansion of the Department's agenda of improved services for the poor. These initiatives are listed below and described in detail in the accompanying narrative. They include at least seven programs begun in FY84 and FY85, when the administration, legislature, and advocacy community were focused on providing desperately needed services to specific vulnerable populations. Several of these services filled gaps created by the Reagan Administration in 1981. As the table below shows, the improved services agenda proposed in H.1 totals to \$216.9 million in new and continuing initiatives. A comparable list in FY83 would have included only three items totalling \$21.9 million.

IMPROVED SERVICES TO THE POOR

10% CoL for AFDC & GR	\$ 54.5M
Clothing Allowance for AFDC & GR	\$ 22.4M
ET Health Services	\$ 1.4M
GR Health Services	\$ 16.0M
Supplemental Benefits	\$ 0.6M
Family Reunification Benefits	\$ 0.4M
AFDC Emergency Assistance	\$ 39.1M
GR Emergency Assistance	\$ 3.5M
GR ET Program	\$ 2.4M
ET and Day Care	\$ 55.8M
Homeless Health Services	\$ 0.8M
Emergency Shelter and Housing Services	\$ 12.5M
\$50 Child Support Disregard	\$ 7.5M
	\$216.9M

D. Maintain low error rates

Over the past three years, the agency, with key support from the legislature and the administration, has succeeded in reducing the AFDC and Medicaid error rates to record low levels. That accomplishment is the result of a broad improvement in local office performance. Reducing worker caseloads to a more manageable 170 cases per worker from the 210:1 or 220:1 ratios which characterized FY82 and FY83 was a critical factor in making this performance improvement possible, as were improvements in local office salaries, space, and working conditions.

However, we have not totally eliminated error in determining eligibility for AFDC, Medicaid, Food Stamps, or other Department programs since the existing eligibility management system is paper-intensive and relies on computer systems installed as far back as 1970. In fact, the Department currently must maintain five separate eligibility files for its programs. Moreover, while local office staff have succeeded in reducing error, their jobs continue to consist primarily of managing paper, not services for clients.

In recognition of this problem, H.1 proposes funds to complete the development and implementation of the Massachusetts Public Assistance Control System (MPACS). As described in detail in this budget narrative, the system will eliminate most of the paperwork and manual computations which characterize the existing system and which result in errors. Indeed, MPACS, combined with continued strong worker performance, offers us the opportunity to make low error rates permanent. We have received initial approval from the federal government of

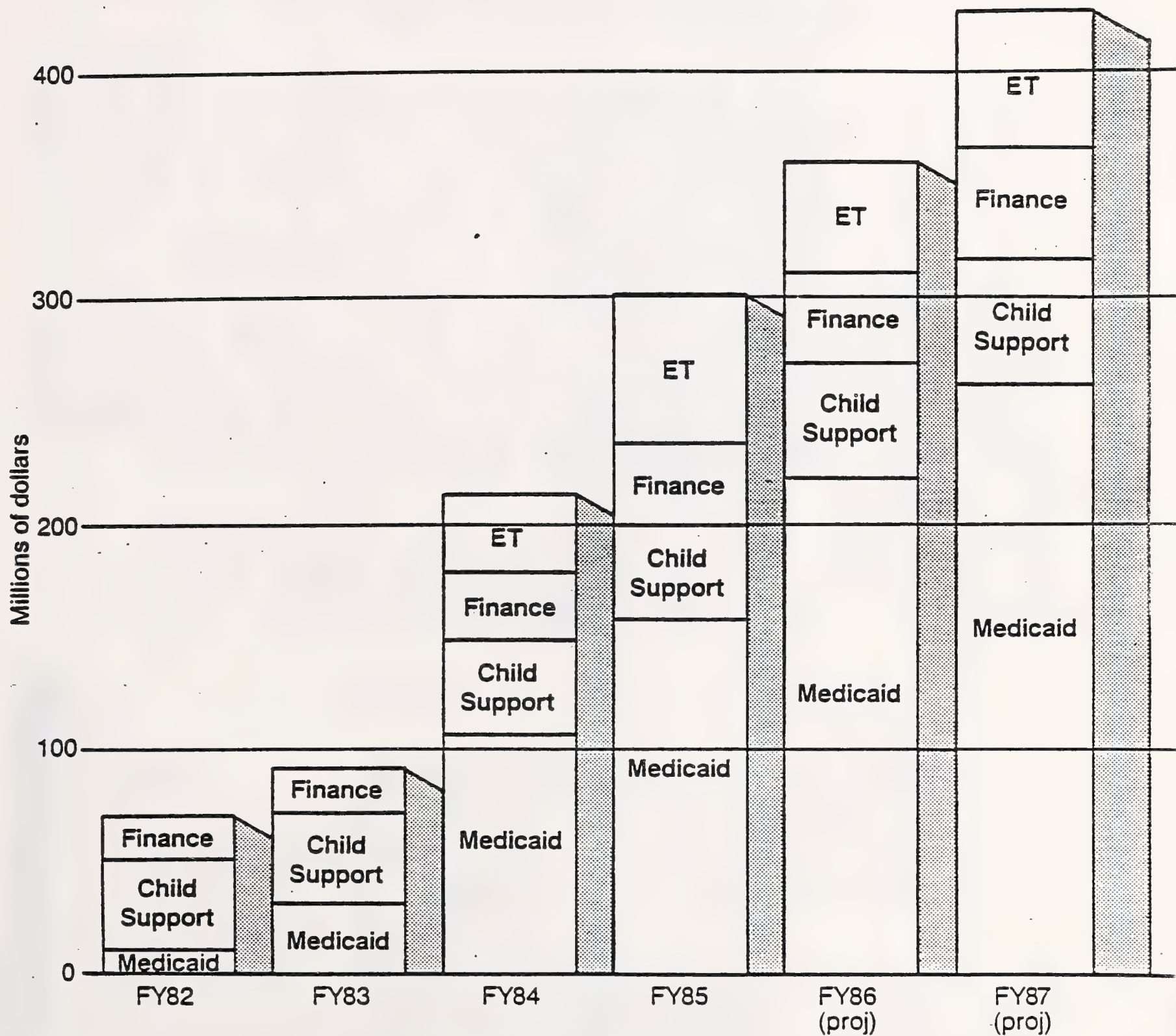
enhanced reimbursement which will cover as much as 85% of the system's development costs. The funds requested for FY87, the strong support the administration and legislature have already provided, and careful attention to worker retraining and other implementation problems should enable us to make the system fully operational statewide by the end of FY87.

We will then begin to make use of MPACS to change what our workers do. Instead of managing paper, our workers will use their time to make sure that clients are getting the services they need -- and that those services are being managed. This approach will produce savings in Medicaid and in Emergency Assistance, and, more importantly, will enable us to use workers as an anti-poverty case management team focused on assisting clients to move out of poverty.

E. Savings and Revenue

Controlling the cost of agency operations will continue to be a high priority in FY87. The growth proposed for FY87 in savings and revenue, at 19.7% or \$70 million, is substantial and will bring the total of new and continuing savings and revenue to \$428.5 million. Further, as the chart below shows, the increase in the scope and yield of the agency's savings and revenue activities since FY83 is enormous: in that year, the total yield was \$92.1 million, and both Child Support and Finance collections brought in no more than they had in the previous year. In FY86, projected performance is \$358 million in new and continuing savings and revenue -- and performance for the first six months suggests that we may well meet that goal.

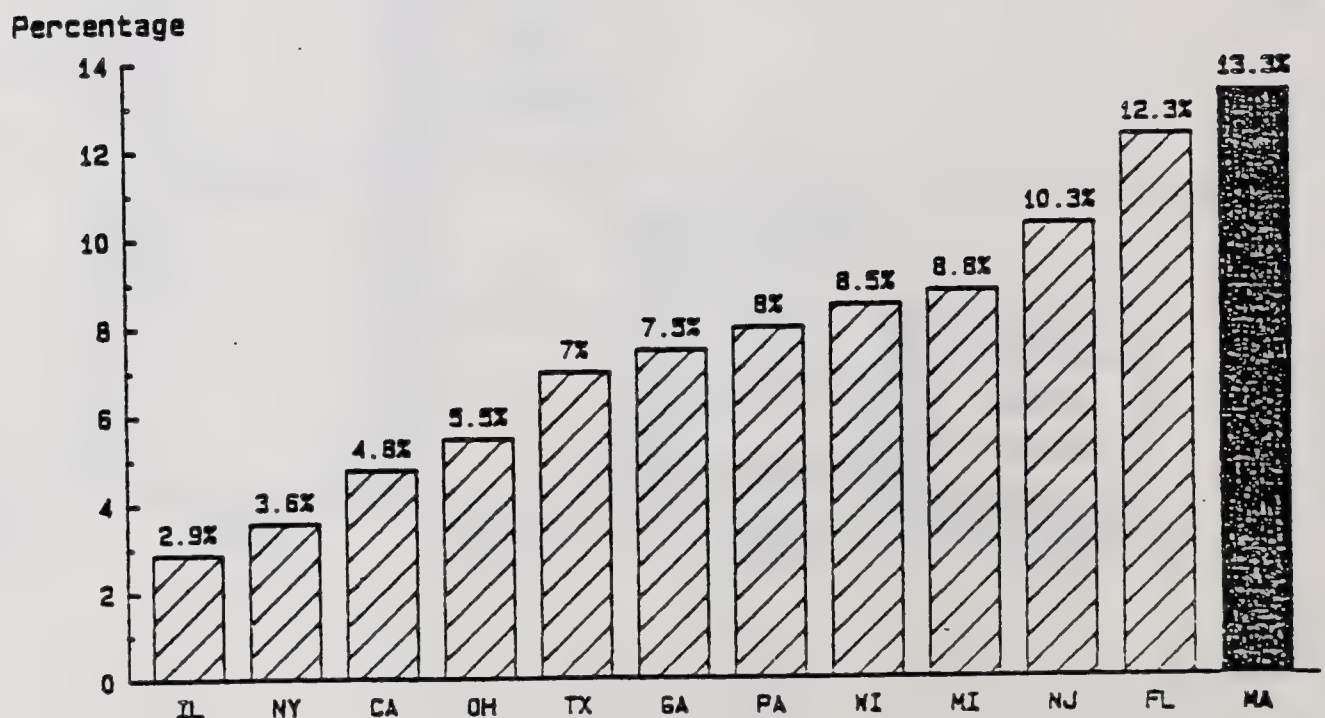
SAVINGS AND REVENUE ARE UP (\$)



One of the most important contributors to controlling expenditures is the Medicaid Management Information System (MMIS), the computerized claims processing system which the Department implemented in FY84 after more than a decade of unsuccessful attempts. Over the past 2 1/2 years of MMIS operation, the number of claims the Department denied doubled compared with the denial rate under the previous procedures, and the agency thereby saves \$56 million each year in funds it otherwise would have spent.

Another perspective on the magnitude of savings and revenue activities is that without the FY87 impact of new and continuing savings and revenue activities, the amount of the FY87 request would only carry the Department through 10 months of the year. In the last three years, savings and revenue efforts have expanded to the point where they effectively finance 2 months of agency operations. As is always the case, the increase in savings and revenue proposed for FY87 will require some investment in administrative resources. In Child Support, for instance, we are proposing to increase collections by more than \$6 million in return for \$2 million in additional resources for performance-based contracting and for computer improvement. We also expect that our Child Support program will remain, as it is now, the most effective of the twelve largest industrial states in terms of percentage of AFDC spending offset by Child Support collections.

Child Support Collections as a Percentage of AFDC Costs Largest Welfare States, FFY1984



Source: 9th Annual Report to Congress
U.S. Department of Health and Human Services

F. Health Choices For Families and Children

H.1 includes funds for the first year of a comprehensive effort to restructure the existing Medicaid program so that Medicaid recipients will have the same health care choices as non-poor citizens of the Commonwealth. This effort, patterned after the successful ET Choices program, will begin with the health services we offer to families and children.

The present Medicaid system has a number of flaws. It provides poor people with little or no access to comprehensive and coordinated ambulatory care. The program has no ongoing system for monitoring the quality of the care these clients receive. The program pays providers on a fee-for-service basis, encouraging them to provide more services and more intensive treatment than patients may need. These and other problems add up to a situation in which Medicaid families often do not receive care which is comparable in quality to the care which other citizens of the Commonwealth receive. Further, the care clients do receive is delivered inefficiently. Clients receive primary care in hospital outpatient departments instead of health centers, and are hospitalized for routine problems in teaching hospitals instead of community hospitals. Over 50% of the Department's \$200 million ambulatory care expenditures reimburse teaching hospital outpatient departments. Much of this care should be provided by physicians and neighborhood health centers. These and other inefficiencies waste taxpayer money -- and also absorb funds which could be used to meet other client needs. In FY72, the AFDC and Medicaid budgets were about the same. By FY85, AFDC had grown by 62% while Medicaid, in part because of these inefficiencies, had grown by 244%.

H.1 proposes to replace this system with one which offers three choices:

- o private insurance - under a negotiated agreement between the state and one or more prospective private insurers, Medicaid-eligible families would enroll in a private insurance plan such as Blue Cross Master Health Plus or Prudential Care. Clients who choose this option would no longer carry Medicaid cards and in fact would be indistinguishable from the other members of the insurance plan.
- o coordinated health - clients would choose a single primary care provider (i.e., community health center, health maintenance organization, or physician) to provide or authorize all necessary health care services. Again, many clients would trade their Medicaid cards for cards identifying them as members of a health plan. Community health centers, the traditional providers of

low-cost, high-quality primary care in urban areas, will be the key resource to provide managed health care options to Medicaid clients where no HMOs exist.

- o basic Medicaid - services provided through a fee-for-service system revamped to incorporate generally accepted utilization controls.

H.1 recommends funds to develop and begin implementation of Health Choices, which I believe will offer clients substantially better quality care than the existing system. Further, Health Choices should produce savings by eliminating a number of the current system's inefficiencies. I propose that, as with the savings ET has produced, we return at least some of the savings Health Choices will provide to the clients.

IV. Conclusion

The narrative which follows provides more information about H.1 recommendations for the agency and provides an overview of all Department programs. I appreciate the role you and other members of the administration played in working with me and my staff to produce what I believe is the most progressive and management-oriented welfare budget recommendation in the agency's history. I look forward to working with you to present these recommendations to the legislature.

FY87 BUDGET REQUEST

NARRATIVE

**COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC WELFARE**

CHARLES M. ATKINS, COMMISSIONER

ACKNOWLEDGEMENTS

A document of this kind requires an extraordinary level of commitment from both the Budget staff and our colleagues throughout the Department. We want especially to thank Andy Bader, Carol Lukas, Alan Werner, and their associates in Research, Planning, and Evaluation; the staff of the Medical Division, who contributed their time and expertise to the Medicaid narratives; and the Department's management services and printing staff, who make this and several other volumes possible each year. Most of all, this document is the work of Genia Long, who managed its preparation, and the Budgeteers, whom we list below.

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OPPORTUNITY FOR ALL: ANTIPOVERTY INITIATIVES, 1983-1986

Since 1983, the combined efforts of the Dukakis administration, the legislature and the human services community have resulted in a comprehensive attack on poverty in Massachusetts. As a result of these efforts and the strong Massachusetts economy,

- o the poverty rate in Massachusetts was 6.5% in 1983 -- nearly half the nationwide poverty rate of 14.2%,
- o the average AFDC caseload reached a 12 year low of 84,391 in FY85,
- o the Massachusetts black unemployment rate in 1985 of 5.3% was below both the U.S. unemployment rate of 7.2% for the total population and the U.S. black unemployment rate of 15.1%.

Despite this progress, the poverty rate of certain segments of the population remains unacceptably high. In 1983, 30% of all female household heads, 26% of all minorities, and nearly one in seven Massachusetts children were in poverty. Thus, it will be critical to make further efforts to reduce poverty through the proposed FY86 and FY87 initiatives. Key initiatives implemented since 1983 to alleviate poverty include:

1. Maintaining a Strong Economy
2. Employment and Training Choices Program
3. Benefit Increases
4. Expansion of Services for the Homeless
5. Affordable Low-Income Housing
6. Expanded Educational Opportunities
7. Expanded Services to Pregnant Women, Infants, and Children
8. Improved Health Care for the Poor
9. Improved Child Support Services
10. Improved Community Services for the Elderly
11. Improved Management of Benefit Programs
12. Expanded Day Care Services
13. Services to Disabled Citizens

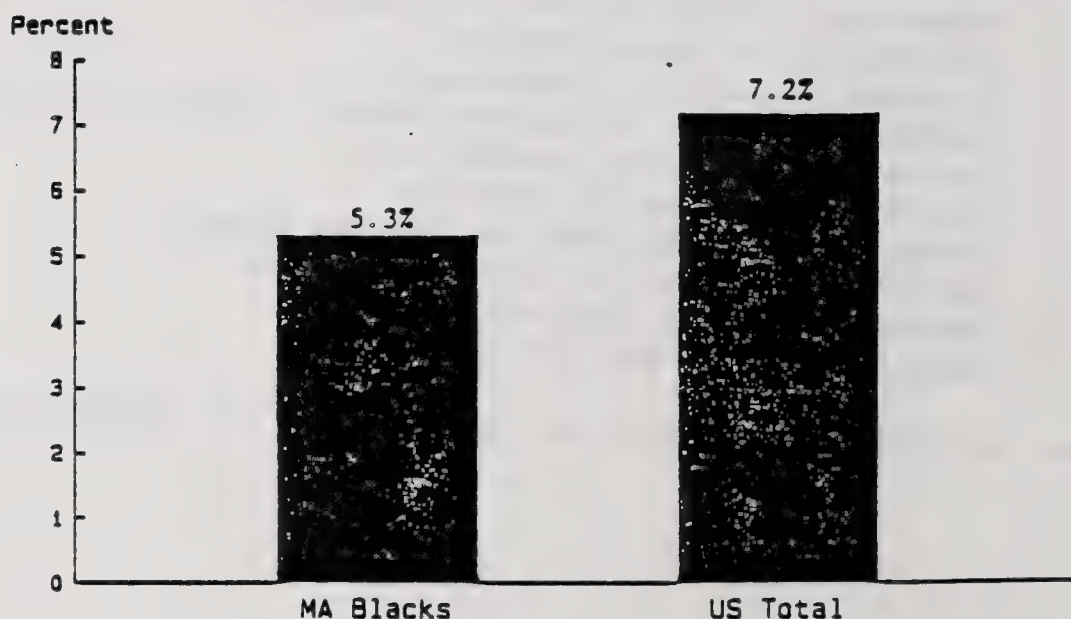
These initiatives are described in detail on the following pages.

1. Maintaining a Strong Economy

Since 1983, as the result of the efforts of the Dukakis administration, the legislature, and the continuing cooperation of private industry, the Massachusetts economy has strengthened and expanded significantly. This expansion has provided enhanced opportunities and greater prosperity for the majority of Massachusetts citizens, including low-income families.

- o Between 1983 and 1984, over 285,000 new jobs were created in Massachusetts. At an annual growth rate of 5.9%, the 1984 employment gain was the largest in Massachusetts since WWII.
- o Employment expanded in all sectors of the economy (except government) between 1983 and 1984. Construction registered an extraordinary growth rate of 16.3%.
- o Each of the state's eleven labor market areas had employment gains between 1983 and 1984, ranging from 3% in Fitchburg-Leominster to 9.7% in Lowell.
- o The Massachusetts black unemployment rate of 5.3% in 1985 was below the U.S. unemployment rate of 7.2% for the total U.S. population, and only one-third the U.S. black unemployment rate of 15.2%.

**Unemployment Rates
MA Blacks V. U.S. Total
1985**



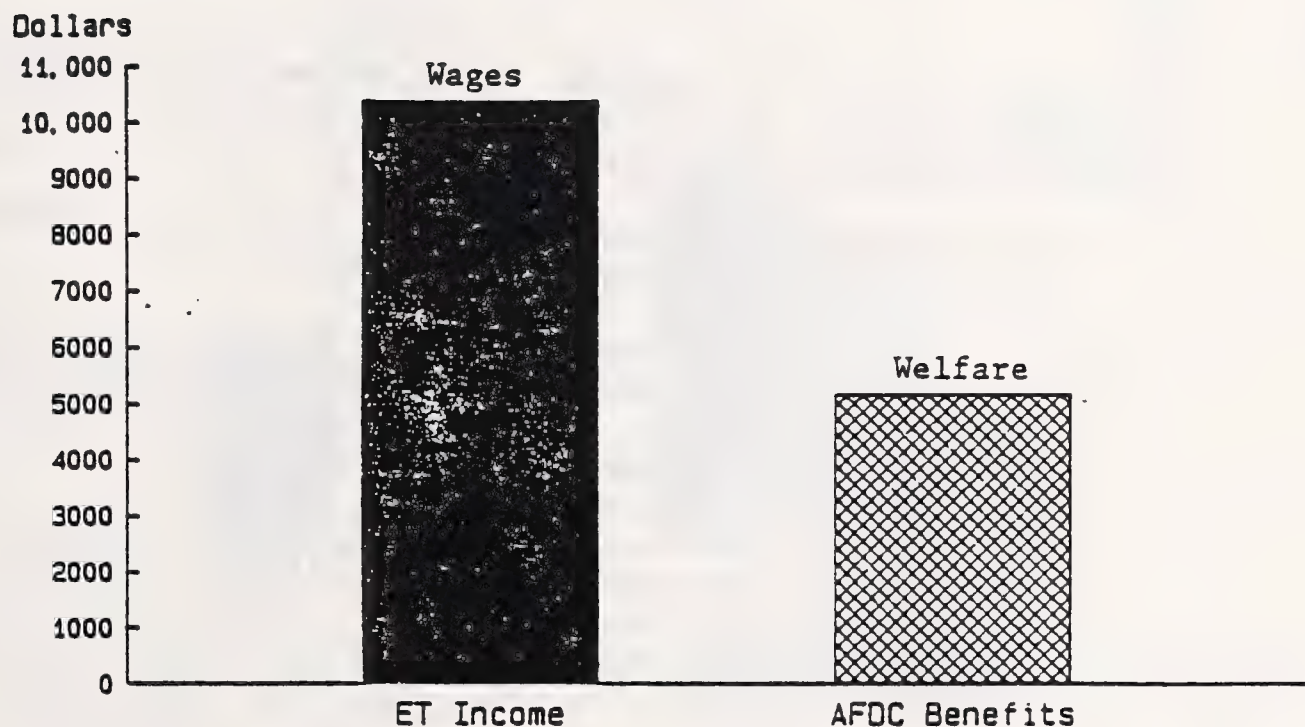
- o In 1986 and 1987, the phase-in of the tax-cut recently passed by the legislature and approved by the Governor will significantly benefit low-income individuals in the Commonwealth. Individuals and couples earning less than \$10,000 will be virtually exempt from state income taxes, while elderly couples and single parent families earning \$15,000 will have their state taxes more than halved.

2. Employment and Training Choices Program (ET)

The majority of welfare clients want realistic ways to move off welfare and out of poverty. When offered the opportunity to leave welfare through adequate employment, they will willingly do so. The Massachusetts Welfare Department has pioneered a creative employment and training program for welfare recipients called ET CHOICES. Combining education, training, and job search services with day care and a growing economy, ET has resulted in:

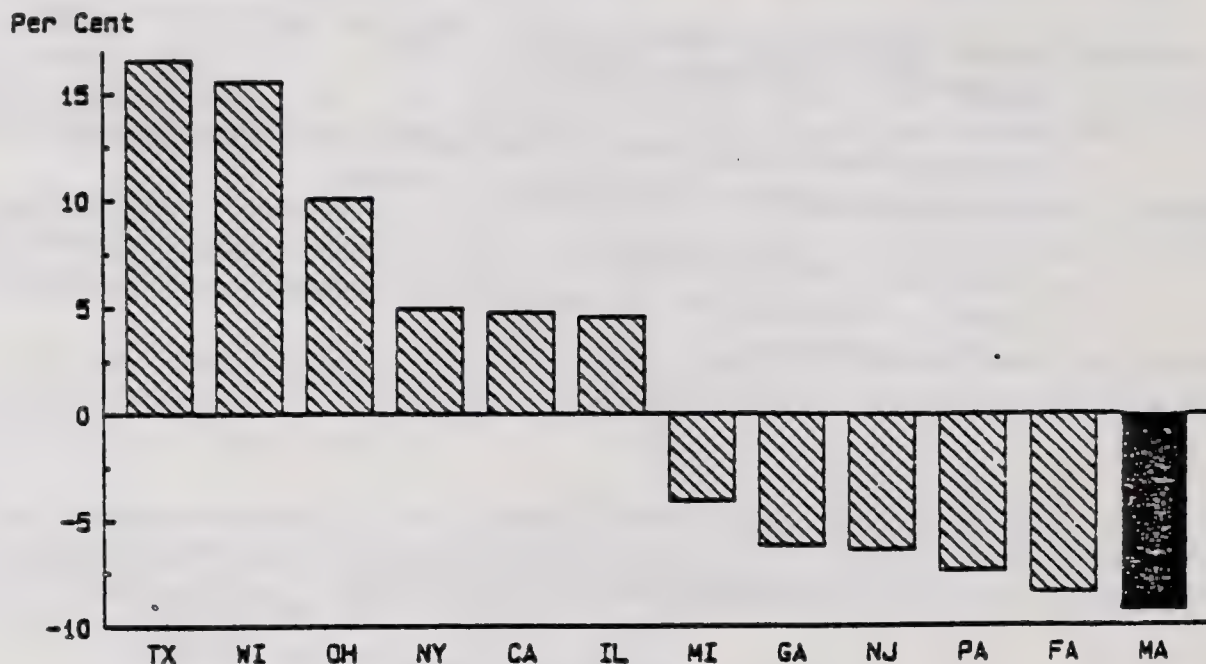
- o over 23,000 placements into full or part-time jobs since its inception in October 1983.
- o savings to Massachusetts taxpayers of an estimated \$69 million in welfare grants and Medicaid costs.
- o average starting wages in full-time jobs of over \$5.00 per hour, yielding an annual income more than twice as high as welfare grants.

**Average Annual Income of ET Placements
Vs. AFDC Cash Benefits
For a Family of Three**



- o the lowest average annual welfare caseload in Massachusetts in 12 years, and the largest decline in welfare rolls in the country since ET began 2 years ago.

**AFDC Caseload Change
Top 12 Caseload States
January 1983 to July 1985**



In addition to the ET Program, which serves AFDC recipients, the following programs have also provided employment and training services to needy populations:

- o The Massachusetts Rehabilitation Commission placed 4,800 individuals into employment during FY85.
- o The Department of Social Services has operated a one year pilot project to provide employment and training services to older adolescents in foster, shelter, or group care. This program served an average of 80 participants, and provided summer jobs for 32 teens.
- o The Executive Office of Economic Affairs, through the Job Training Partnership Act (JTPA), served more than 16,000 individuals during FY85 and placed 6,500 non-welfare clients into employment.
- o The Department of Corrections has provided supervised employment opportunities in manufacturing plants to 480 prison inmates and 160 civilians.
- o The Executive Office of Economic Affairs has administered an employment and training program for 2,000 ex-offenders, and has placed 1,200 into unsubsidized employment.

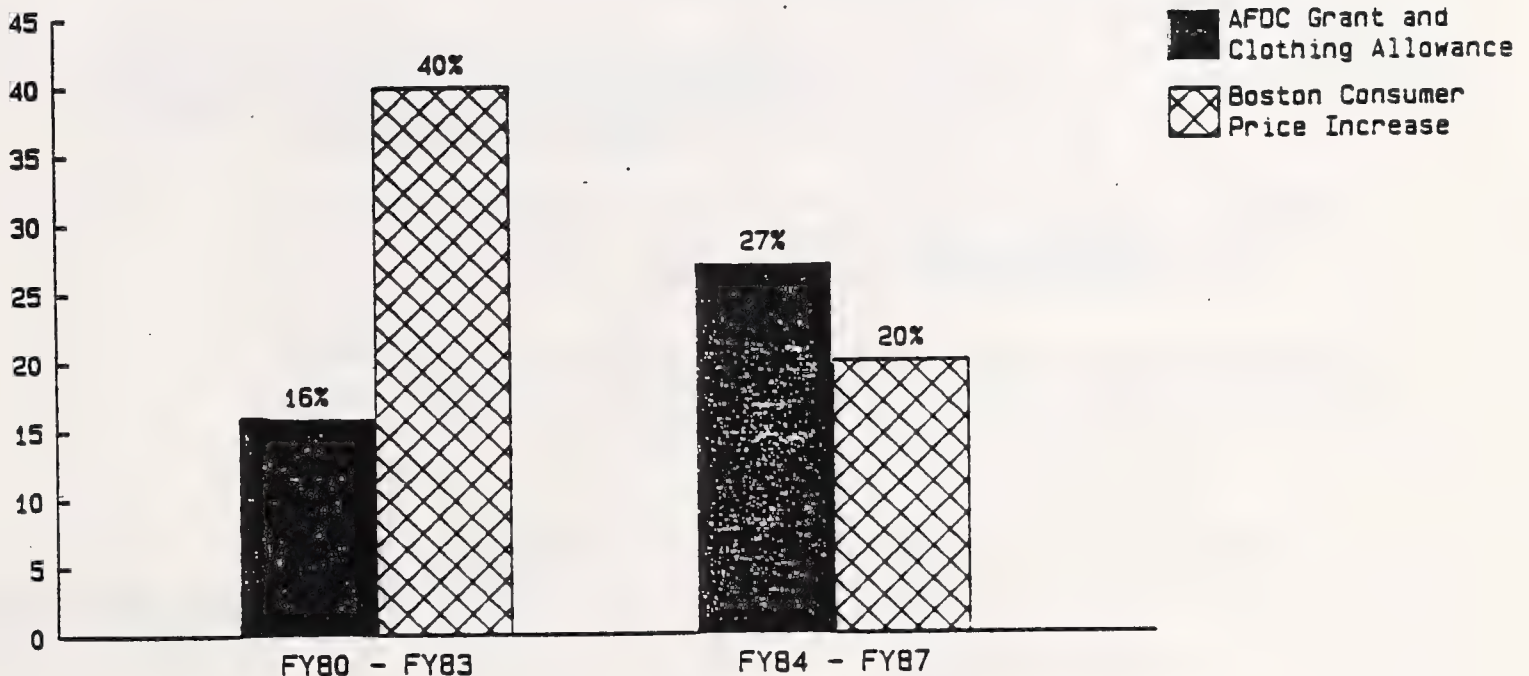
- o Since FY83, the Bay State Skills Corporation has offered employment and training services to over 9,000 individuals and placed over 2,300 into employment.
- o The Department of Public Health has provided employment services to ex-alcoholics and ex-addicts and placed 60 ex-addicts into unsubsidized employment.

3. Benefit Increases

In 1973, welfare benefits in Massachusetts were 15% above the federal poverty level. By 1983, welfare benefits were 20% below the federal poverty level because of inflation over that 10 year period. As the following chart shows, inflation particularly outstripped benefit increases in Massachusetts from 1980 to 1983. However, over the past 3 years the Dukakis administration and the Massachusetts legislature have provided benefit increases, which, for the first 3 year period in 15 years, more than kept up with inflation. In FY87, the Governor is requesting a 10% increase in welfare benefits. If approved, the cumulative increase in benefits since FY83 will total 27%, 7% more than inflation.

**AFDC Grant Increases V Inflation
FY80 - FY87**

Percent Increase



In addition to the 16% increase in AFDC benefit levels over the past 3 years and the requested 10% increase in FY87, other benefit increases have included:

- o increases in General Relief benefit levels totaling more than \$15 million,

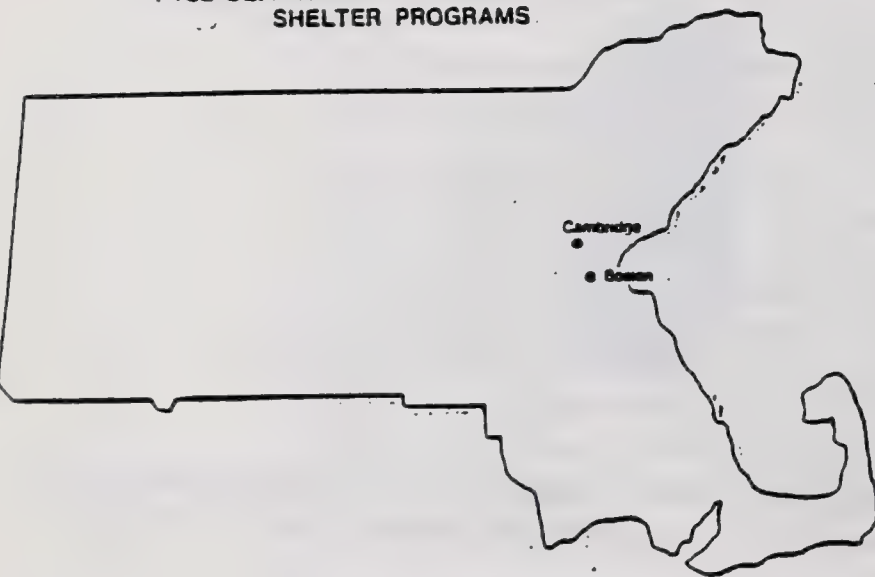
- o a \$125 clothing allowance for each AFDC child and a \$90 clothing allowance for each GR client each September for the past three years.
- o a family reunification benefits program, begun in October 1984, to offer continued cash assistance to families whose children are temporarily placed in state care, to prevent those families from becoming homeless as they prepare for the return of their children,
- o supplemental payments to an average of over 600 families per month in FY85 to protect working clients from reductions in their monthly income due to a federally mandated retrospective budget process,
- o increases in the AFDC income eligibility standard of 5% each year in FY83, FY84, and FY85 to extend eligibility to working poor families.

4. Expansion of Services for the Homeless

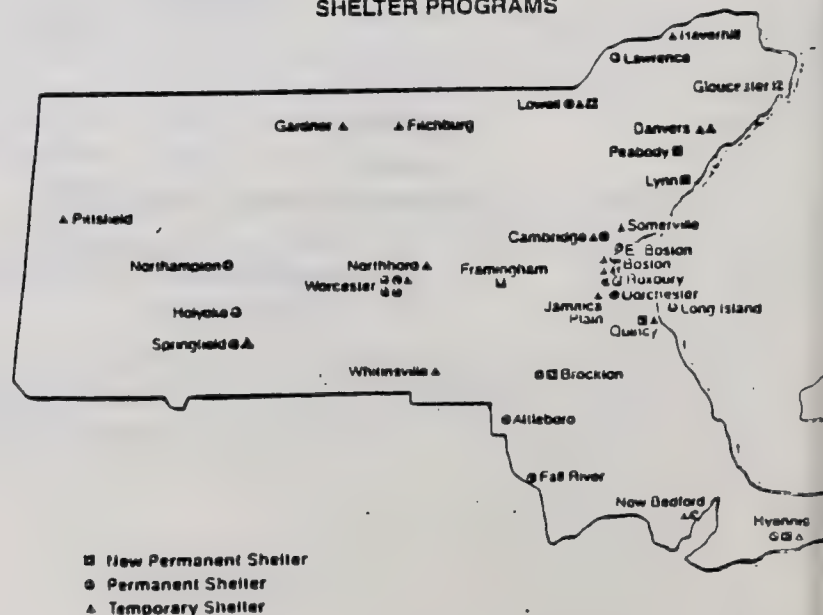
In response to the increasingly serious problem of homelessness in the Commonwealth, the legislature, the administration, and the human service community have cooperated to:

- o increase the number of Welfare-funded shelters from 2 in 1983 to over 51 permanent and temporary shelters in 1986, and thus expand the number of shelter beds from 450 to 1,700.

FY82 DEPARTMENT OF PUBLIC WELFARE
SHELTER PROGRAMS



1985-86 DEPARTMENT OF PUBLIC WELFARE
SHELTER PROGRAMS



- o provide \$60 million of hospital and other medical services to GR recipients and medical outreach to individuals living in shelters,
- o pass legislation in 1983 to enable homeless individuals with no address to receive General Relief,
- o change welfare policy to allow clients with no address to receive food stamps,
- o deploy 13 additional DSS staff in FY86 to provide housing search assistance to clients living in Welfare funded hotels and motels,
- o open 2 EOHS funded day facilities to provide services such as hot meals, counseling and referrals to homeless clients,
- o provide EOCD funds to 12 nonprofit organizations to mediate landlord/tenant disputes to prevent evictions,
- o reform the Emergency Assistance program to make it more responsive to client circumstances. Prior to 1983, there were restrictive caps on the amount of benefits authorized for EA. As a result, the needs of many families were not fully met. In 1984, the legislature dramatically expanded Emergency Assistance services, resulting in an increase in total expenditures from \$7.5 million in FY83 to \$24 million in FY85. Key reforms include:
 - eliminating restrictive caps on the amount of payments for utility and rent arrearages, advance rent and security deposits, and hotel and motel stays,
 - authorizing Emergency Assistance for the prevention of homelessness during certain critical situations such as residential over-crowding or violence against a family member,
 - adding an Emergency Assistance program for GR clients in January 1985.

5. Affordable Low-Income Housing

Homelessness is due, in part, to a shortage of housing for low and moderate income families and individuals. This problem has been exacerbated by the conversion of low and moderate priced housing units into high-priced condominiums. In Boston alone, between 1980 and 1983, over 7000 condominiums were created at a median price of \$62,000 -- well out of the price range of welfare clients.

In response to this situation, the legislature enacted tough legislation in 1983 to restrict condominium conversion. Chapter 527 of the Acts of 1983 required that prior to converting an apartment to a condominium, a landlord must:

- o give one year notice to all tenants, and two years notice to low and moderate income, elderly, and handicapped tenants,
- o give an additional two year extension to low and moderate income, elderly and handicapped tenants if the landlord cannot locate comparable housing within the notification period,
- o pay moving expenses of \$750 to most tenants and \$1000 to low and moderate income, elderly or handicapped tenants,
- o restrict all rent increases during the notification period to the increase in the CPI or 10%, whichever is lower.

In addition, EOCD and the legislature has acted to increase the supply of affordable low-income housing. To date, almost 15,000 additional low and moderate income units have been provided, including:

- o 2,600 units by the Comprehensive Housing Act of 1983,
- o 3,380 units through the SHARP interest subsidy program,
- o 3,500 units as result of expanding rental assistance programs such as Chapter 707,
- o 4,800 units by providing moderate income mortgages, and
- o 400 units for the mentally retarded through a consent degree agreement.

In 1985 and 1986 EOCD intends to provide an additional 18,200 units of low-income housing, including:

- o 3,500 units through the \$344.4 million housing bond bill passed in December 1985,
- o 4,000 units through the expansion of the SHARP interest subsidy program,
- o 2,000 units by expanding current rental assistance programs,

- o 4,000 units as a result of the TELLER Tax Exempt Loan Program,
- o 4,700 units by providing additional moderate income mortgages.

In just four years, more than 32,000 units of low and moderate income housing will have been provided for the state's needy citizens.

6. Expanded Educational Opportunity

Providing quality education is a basic and necessary investment in the future of the Commonwealth and her citizens. Access to education for all segments of society, regardless of economic status, is a fundamental key toward making opportunity for all a reality. In the last three years, Massachusetts has improved both the quality of and access to elementary, secondary and higher education. Improvements include:

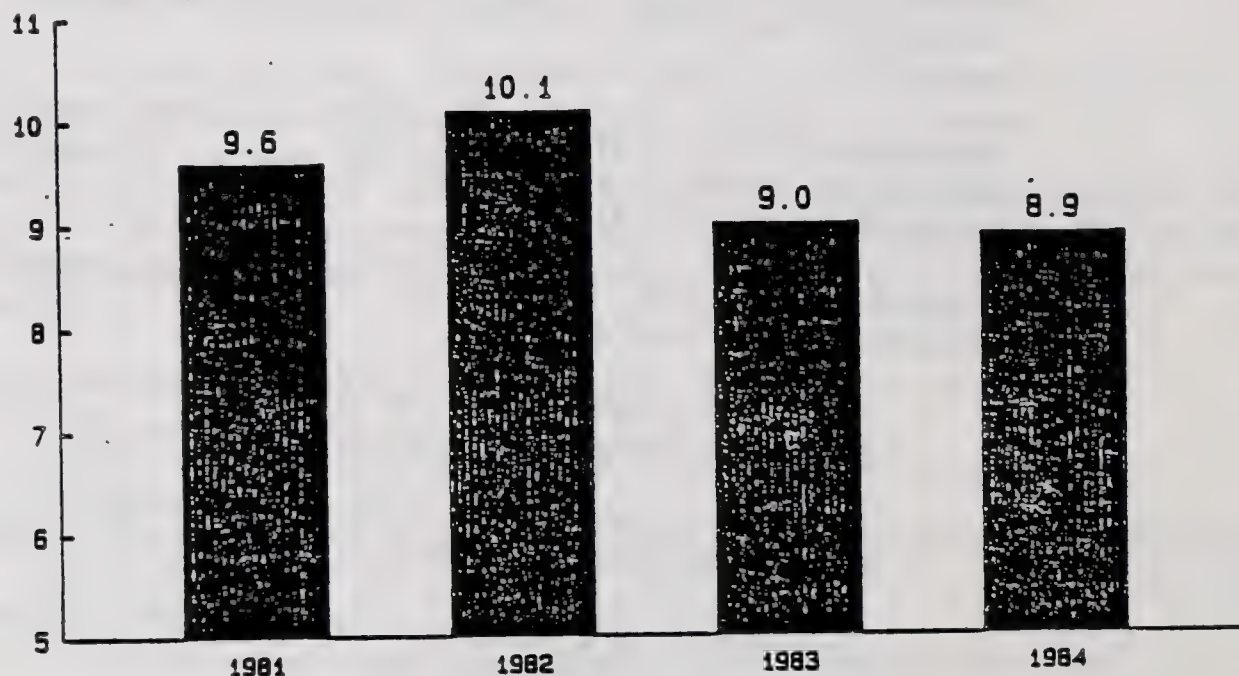
- o Providing \$25 million of state subsidies to low-spending public school districts in FY86, through the Public School Improvement Act of 1985 (Ch. 188). This program will provide subsidies to all school districts which spend less than 85% of the state's median per pupil expenditure. In FY86, this program will help 142 of the state's 346 public school districts, and 82% of AFDC recipients enrolled in public schools.
- o Increasing state support of higher education by 51% over the past three years -- well above the average nationwide increase over the period of 31%.
- o Expanding access to postsecondary education for the Commonwealth's students by:
 - increasing appropriations for scholarships by 203% from \$19.0 million in FY83 to \$57.5 million in FY86.
 - initiating an Adult Learner Scholarship program to assist welfare recipients in attending college.
 - initiating the Commonwealth Scholars Program to award grants to meritorious high school students to help them continue their education.
 - providing state assistance to a total of 50,000 students per year to pay all or part of their educational expenses at both public and independent colleges and universities.

7. Expanded Services to Pregnant Women, Infants, and Children

In recognition of the key role that early intervention plays in ensuring the health of children and in preventing infant mortality, the Administration, legislature and the human services community have moved to expand services and benefits available to pregnant women and very young children. These actions helped to stem the rising infant mortality rate, which, for the first time in nearly 2 decades, had increased from 9.6 deaths per 1000 births in 1981 to 10.1 in 1982. Since then, the infant mortality rate declined to 8.9 deaths per 1000 live births in 1983 -- the lowest rate ever.

Massachusetts Infant Mortality Rates
1981 - 1984

Deaths Per 1000 Live Births



1984 mortality rate is the lowest ever
in Massachusetts.

Efforts to serve pregnant women, infants, and children include:

- o making women eligible for AFDC benefits during their first and second trimesters of pregnancy (a benefit removed by the Reagan administration in 1981),
- o becoming the first state in the nation to supplement its Women, Infants, and Children (WIC) nutrition program with state funds, more than doubling the number of families served from 30,000 in 1982 to 63,000 in 1985,
- o approving a new \$6 million program to provide health care benefits to over 4000 uninsured low-income women who are pregnant,
- o almost doubling the number of high risk infants who are served by visiting nurses (from less than 2,000 to 3,500),
- o creating 23 DPH-funded Maternal and Infant Care Projects which provide prenatal and post partum care to 4,000 low-income women,
- o funding adolescent pregnancy parenting programs to provide health, educational, and psycho-social services to 6000 women and infants,
- o establishing Failure-to-Thrive programs which provide diagnosis, treatment and referral services to 500 children with severe growth retardation.

8. Improved Health Care for the Poor

Working through human services agencies, the Welfare Department has implemented a number of initiatives designed to improve both the access to and the quality of health care services for low-income families and individuals. These include:

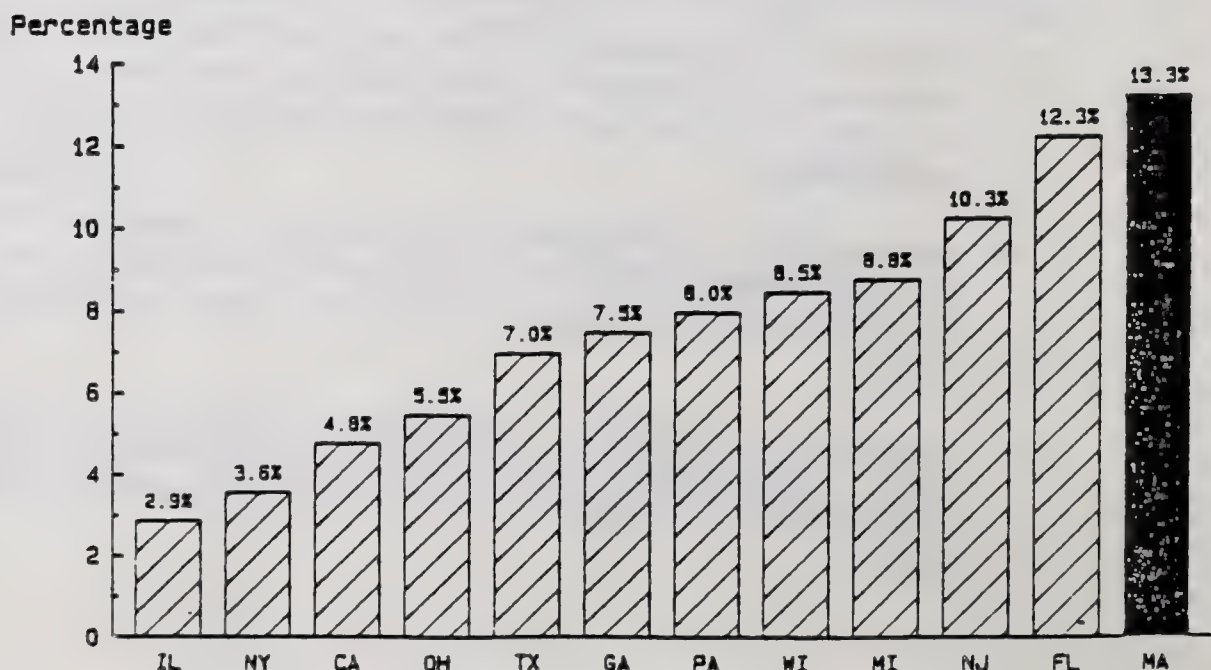
- o increasing by 132% the number of children enrolled in Project Good Health (a preventive medical program for children in welfare families) from 37,000 in 1983 to 86,000 in 1985;
- o assuring GR clients access to the same full range of acute hospital care services available to Medicaid clients, as part of the \$55 million Medicaid acute hospital legislation settlement;
- o increasing the Medicaid eligibility standards for individuals by 32% between FY83 and FY86, and for families by 14%, thereby increasing the number of families and individuals served by 3,300;
- o sponsoring spenddown legislation which was enacted in 1984 to allow 500 elderly and disabled individuals to become eligible for Medicaid without being forced to enter expensive nursing homes.

9. Improved Child Support Services

Most welfare recipients are families consisting of mothers and small children. These families stay on welfare for an average of only two years. Over 90% need assistance because an absent father fails to provide support. If absent fathers met their legal and moral obligation to support their families, welfare rolls could be dramatically reduced. In recognition of the key role that child support can play in preventing families from becoming poor and in moving poor families out of poverty, the Welfare Department, the Massachusetts legislature, the courts, and other agencies have:

- o increased child support collections to a record \$45 million in FY85, 13% more than in FY83, despite the fact that the AFDC caseload has declined by nearly 10% over the same period.
- o established, through Welfare Department staff and local courts, 12,471 new child support orders in FY85 for AFDC families, and located 7,691 additional absent parents in FY85,
- o passed legislation in 1983 authorizing automatic wage withholding for parents who are delinquent in child support payments,
- o begun a new federally mandated program which allows AFDC families to keep the first \$50 of child support collected on their behalf without reducing their benefits,
- o initiated contracts between the Welfare Department and private collection agencies to locate more absent fathers and collect child support arrearages,
- o collected a larger proportion of their total AFDC costs in child support collections than any of the 12 largest welfare states.

**Child Support Collections
As a Percentage of AFDC Costs
Largest Welfare States, FFY1984**



10. Improved Community Services for the Elderly

The single largest category of expenditure within the state's Medicaid program, almost 50% of the budget, is institutional care for elderly citizens. This extensive use of institutional care is undesirable because it removes clients from their families and reduces client self-sufficiency, and because it represents a large expense for the Commonwealth. It is both possible and desirable to maintain more low-income elderly in the community. The key to this effort is a health care and social service delivery system which identifies and responds quickly, effectively, and flexibly to the needs of the elderly population. The Welfare Department, the Department of Elder Affairs and the Massachusetts legislature have made a concerted effort to serve the elderly in the community by:

- o providing Supplemental Security Income benefit levels for aged and disabled Massachusetts citizens that are the fourth highest in the nation;
- o providing, through the Department of Elder Affairs, an elder services network which reaches 50% of the state's elderly, and is the largest such state-funded program in the country;
- o expanding state appropriations for elder nutrition services by 305% from FY80 to FY84. Providing, through this service, 5.4 million nutritionally sound meals to over 66,000 elders per year;
- o developing a protective services program to respond to elder abuse. This service received reports of over 1,800 cases of abuse in FY85, of which over 1,000 required a response;
- o expanding the state appropriation of the Departments Elder Affairs 65% in 3 years, to provide comprehensive home care services to 44,000 elders to help them remain in the community instead of entering nursing homes;
- o providing health services to an average of 12,500 elderly recipients per month so they can stay at home through services such as home health care, adult day services, and adult foster care;
- o obtaining a federal waiver to secure Medicaid reimbursement for home care services for more than 3,000 frail elderly Medicaid recipients in the community;
- o developing coordinated health care programs to serve both well and frail elderly individuals in an effort to prevent or delay complications that lead to nursing home placement (the Welfare Department has established 36 programs, providing services to over 2,000 elders);

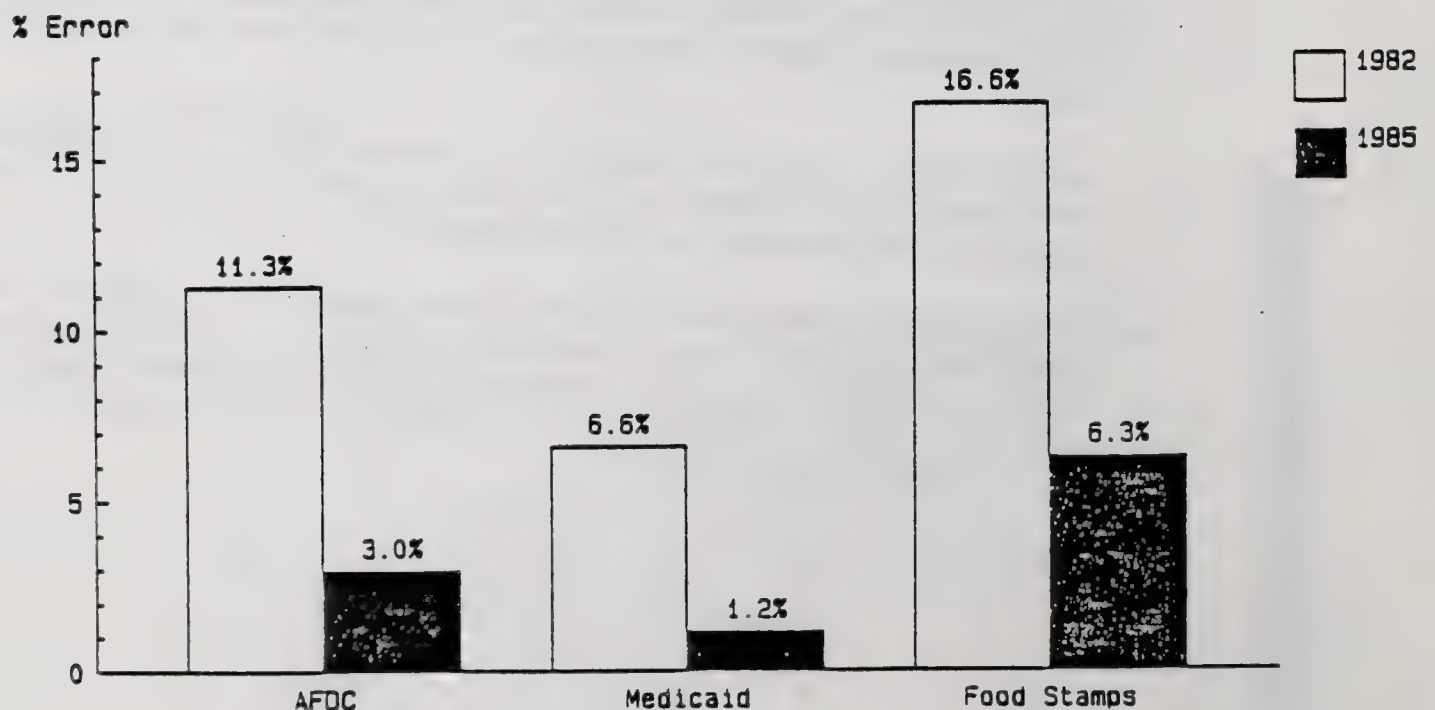
- o enrolling, under the governor's "senior plan", up to 33,000 elderly citizens in health maintenance organizations, prepaid health care programs which emphasize preventive health care;
- o providing Personal Emergency Response System (PERS) services as an alternative to nursing home care. In FY85, 200 individuals received this benefit in two areas of the state. In FY87, the Department proposes to offer PERS statewide, expanding the potential population to 1,000;
- o providing ongoing and preventive medical care to 2,800 elders in nursing homes during FY86 through the use of nurse practitioners and physician's assistants.

11. Improved Management of Benefit Programs

Welfare benefit programs have in the past been viewed by the public as mismanaged efforts, and this common misconception often hinders efforts to improve services for the Commonwealth's needy poor citizens. To dispel this belief, and to help control expenditure growth, the Welfare Department, with the assistance of the Massachusetts legislature, has undertaken an aggressive management effort to reduce error rates and initiate expenditure savings projects. To date, these include:

- o reducing the AFDC error rate from 11.3% in 1982 to 3% in FY85, the Commonwealth's lowest rate ever;
- o reducing the Medicaid error rate from 6.6% in 1982 to 1.2% in FY85, the lowest rate ever in Massachusetts;
- o reducing the Food Stamp error rate from 16.6% in 1982 to 7.7% in FY85, the lowest rate ever;

**Welfare Error Rates
1982 v. 1985**



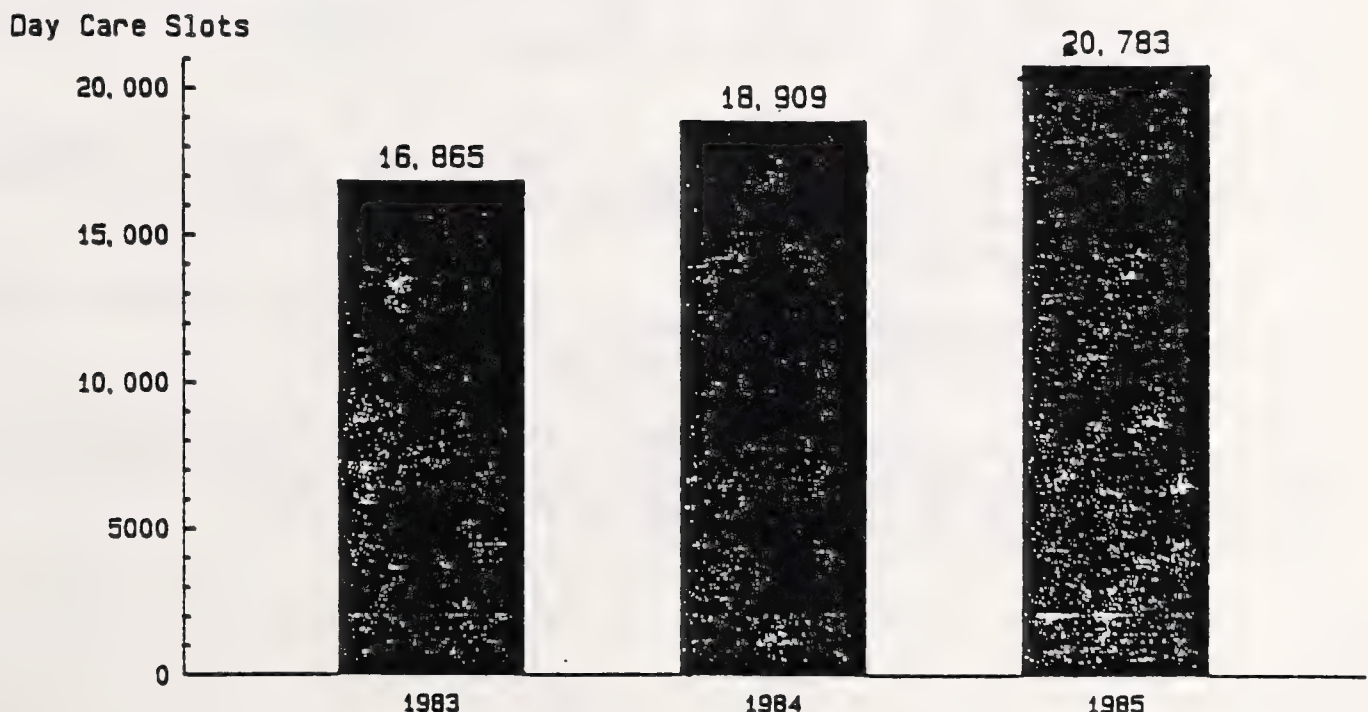
- o saving an estimated \$45 million over the past 2 years in potential fiscal sanctions by the federal government, through reducing error rates in all 3 benefit programs;
- o implementing the Medicaid Management Information System in FY84, a computer system which saved the Commonwealth more than \$50 million dollars in inappropriate Medicaid expenditures in its first year of operation;
- o collecting a record \$45 million in Child Support monies in FY85;
- o designing a new eligibility computer system, MPACS, which will go into operation in FY87. This system will substantially improve the Welfare Department capability to:
 - further improve payment accuracy and reduce the error rate,
 - free workers to manage the delivery of services to clients,
 - afford clients greater access to all welfare programs that they are eligible for.

12. Expanded Day Care Services

Child care is both expensive and difficult to find, posing a major barrier to self-sufficiency for many public assistance recipients and low-income families in the Commonwealth. The Department of Public Welfare and the Department of Social Services have substantially improved both the quality of and access to affordable child care services by:

- o expanding the number of state funded child care slots for low-income families from 16,865 in 1983 to 20,783 in 1985, a 23% increase;

**Massachusetts State Funded Day Care Slots
1983 - 1985**



- o becoming one of only a few states to appropriate state funds for the child care expenses of participants in an employment and training program. Since ET began in October 1983, over \$15 million has been spent to provide day care vouchers to participants and graduates of the ET program. In FY85, 3400 vouchers were available to ET placements;
- o expanding the number of state funded child care slots for protective day care for children in danger of abuse or neglect from 2257 in 1983 to 3721 in FY85;
- o developing a comprehensive state plan for day care through the Governor's Day Care Partnership Project;
- o funding 5 new Child Care Resource and Referral Agencies;
- o adding 20 licensors to the Office for Children so that both the number and quality of child care services can be improved; and
- o upgrading the salaries of human service providers, including child care workers, by 7% in FY86.

13. Services to Disabled Citizens

In March 1981, the federal government ordered an accelerated and restrictive review of persons receiving or applying for disability benefits, in an effort to reduce social service expenditures. By the end of 1982, this had resulted in thousands of Massachusetts citizens being inappropriately denied benefits. Since 1983 the current administration has responded to the plight of the disabled by:

- o improving the Disability Determination Service at the Massachusetts Rehabilitation Commission through a legislatively mandated review commission and by developing new objective disability criteria. As a result of this effort the approval rate for initial disability applications increased from 34% in 1982 to 56% in July 1985. Similarly, approval rates for continuing disability reviews have increased from 65% to 88%.
- o helping 2,300 disabled individuals receive community based care through independent living centers throughout the Commonwealth;
- o maintaining SSI benefits to the elderly, disabled, and blind at or above the federal poverty level;
- o expanding the number of Welfare-funded community based intermediate care facilities for the developmentally disabled from 16 in FY83 to 39 in FY86;

- o expanding by more than 50% the number of day habilitation programs, which provide medical, training and therapeutic services on an outpatient basis to mentally retarded and developmentally disabled adults;
- o enacting "turning 22" legislation to offer DSS counseling and referral services to disabled young adults who lose their entitlement to special education as a result of their turning 22. By July 1986, an anticipated 2,400 individuals will be assisted by this program.
- o offering DSS respite care to 3,400 disabled adults in FY85 to provide brief periods of relief to families caring for a developmentally disabled adult,
- o providing, through the Massachusetts Commission for the Blind, training programs to help 200 blind individuals obtain employment in the private sector,
- o operating one of six extended sheltered employment programs in the nation which enable over 1500 clients per year to be employed in sheltered workshops,
- o providing vocational and rehabilitation services through the Massachusetts Rehabilitation Commission to over 32,000 developmentally disabled adults, and placing over 4,800 in jobs during FY85.

INTRODUCTION TO THE BUDGET

The Department's mission is:

- o to alleviate poverty through cash assistance and related services;
- o to provide opportunity to all clients by creating alternatives to poverty through employment and training and child support;
- o to provide quality, cost-effective health care services to the poor, the elderly, and the disabled; and,
- o to control agency costs by reducing program error rates and increasing savings and revenue.

In pursuing these goals, the Department of Public Welfare provides assistance to over half a million people in the Commonwealth each month through such programs as Aid to Families with Dependent Children, General Relief, Supplemental Security Income, Food Stamps, and Medicaid. The Department operates an innovative program, ET Choices, to extend the same opportunities to welfare clients as are available to other citizens in the state's growing economy. ET has placed more than 23,000 AFDC clients into full or part-time jobs since it began in October 1983. The Department also offers child support services, with the goal of establishing long-run sources of income for the approximately 85,000 AFDC families it serves, more than 90% of which are eligible due to the absence and loss of support of a parent.

Over the past three years, the Department, with the support of the legislature, and the assistance of the Executive Offices of Human Services and Administration and Finance, has been successful in a number of critical areas:

- o increasing assistance to clients through a 16% increase in AFDC grants (including the clothing allowance). The Department is requesting funds for a 10% cost-of-living increase in FY87, bringing the increase to 27% over four years. The \$58 million cost of this FY87 10% increase is more than offset by \$69 million in savings due to ET.
- o placing more than 23,000 AFDC clients into full or part-time jobs through the ET program, resulting in the largest caseload decline over the past 2 1/2 years of any industrial state.
- o reducing the AFDC and Medicaid error rates to their lowest levels in the Department's history. The current AFDC error rate is 3.0%; the current Medicaid error rate is 1.2%.
- o assisting homeless families and individuals by increasing the number of Department-funded temporary and permanent shelters from 5 in FY83 to 51 in FY86. The Department has requested funds in FY87 to increase this number to 61 in FY87.

- o increasing the Department's savings and revenue agenda from \$92.1 million in FY83 to an estimated \$428 million in FY87. Key components of this increase include expanded child support collections, savings due to the implementation of a sophisticated Medicaid management information system, and substantial increases in the Department's Finance Division's ability to recoup overpayments made to providers and recipients.

OUR CLIENTS

Currently, over 500,000 children, families, and disabled and elderly people receive some form of assistance from the Welfare Department. Moreover, about one quarter of the Massachusetts population will require assistance from the Department at some point during their lives. The average welfare recipient's profile, however, might appear surprising.

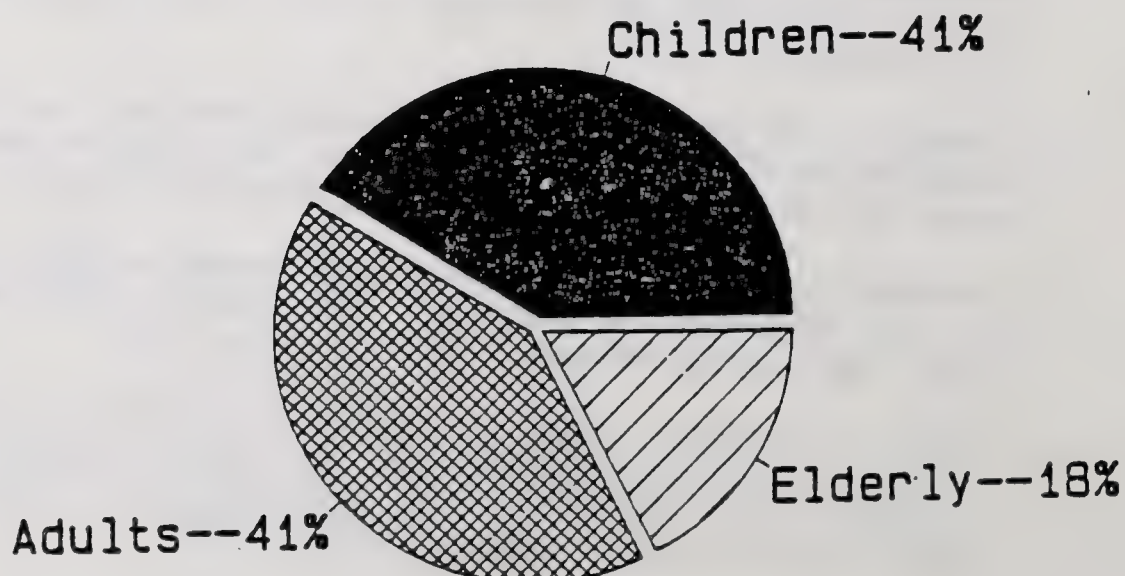
The typical welfare family is:

- white
- composed of a 30 year old mother and two children
- has lived in Massachusetts for ten years
- has received welfare for less than two years
- needs help because an absent parent failed to provide adequate child support

o Children

41% of the Department's clients are children, most of whom are recipients of AFDC, Medicaid, or Food Stamps. Two-thirds of Medicaid clients are children and families.

Department Clients By Age



In fact, two-thirds of AFDC clients are children, qualifying that program as the most significant support program for children in the state. The Department operates a number of programs which offer services to children:

- AFDC
- Medicaid coverage for ongoing and emergency medical care
- Project Good Health, a program of preventive health services for children
- Voucher day care, for children of ET participants
- Food Stamps

o The Elderly

Another 18% of the clients the Department serves are elderly, most of whom receive services through the Supplemental Security Income and Medicaid programs. These clients are frequently people who have been employed all their lives, but who face medical bills, often in a chronic care hospital or nursing home, which overwhelm savings.

THE DEPARTMENT'S PROGRAMS

The Department delivers services to the clients it serves through a set of programs administered in its 69 local offices across the state. Each of these programs is described briefly below.

A. Aid to Families with Dependent Children (AFDC)

AFDC is financed jointly by the Commonwealth and the federal government and provides cash assistance to approximately 85,000 families with children under the age of 18 who meet financial limits on assets and income and who have been deprived of economic support through the death, disability, desertion, chronic unemployment, or continued absence of one parent. In addition, Emergency Assistance is available through the AFDC program to families who are victims of natural disasters, who are homeless or who are at risk of becoming homeless.

B. Employment and Training Choices (ET)

ET provides basic education, skills training, job referral, career counseling, and supported work services to AFDC, GR, and refugee clients, as well as the day care and transportation services which allow participation by a broad range of clients.

C. Homeless Services

The Department supports a statewide network of 51 shelters in FY86, 30 permanent shelters and 21 temporary shelters serving homeless families and individuals. It is requesting funding in FY87 to increase this total to 61 shelters across the state.

D. Medicaid

The Medicaid program provides health care to categorically eligible and medically needy individuals and families. AFDC and SSI recipients are automatically eligible for Medicaid. Other individuals and families are eligible for Medicaid as medically needy if their income and assets are insufficient to pay medical bills and meet established medical needs. More than 190,000 AFDC and SSI clients and 65,000 medically needy clients are eligible for Medicaid each month. Medicaid-funded services are financed jointly by the Commonwealth and the federal government.

E. Food Stamps

The Food Stamp program provides coupons which are used to purchase groceries by households which meet federally determined income and asset tests. Approximately 136,400 households are projected to receive Food Stamps each month in FY87. Although Food Stamp benefits are paid for entirely by the federal government, the Department pays one-half of the administrative costs of the program.

F. General Relief (GR)

GR provides entirely state-funded cash assistance for those clients who are ineligible for other assistance programs and who are "non-employable" due to a physical or mental incapacity. Most GR recipients are adults, although approximately 1,500 families receive GR. With the passage of Chapter 450 of the Acts of 1983, the state extended GR to homeless individuals, and extended Emergency Assistance to GR recipients. GR clients receive a separate package of medical services.

G. Refugee Resettlement Program

Cash and medical assistance are provided to approximately 2,300 refugees who have been in United States less than 37 months, at full federal cost. In addition, social service and employment services are available to all refugees, regardless of length of stay in the country.

H. Supplemental Security Income (SSI)

SSI provides cash assistance to approximately 108,000 long-term disabled and aged poor individuals who meet certain income and asset eligibility standards. In addition, the Massachusetts Commission for the Blind provides assistance to eligible blind individuals. All SSI recipients are also automatically eligible for Medicaid. The Commonwealth supplements established federal payment levels.

AGENCY SPENDING

Through an ambitious agenda of savings and revenue initiatives, the Department has held overall spending growth to an average of only 5% per

year between FY83 and FY86, roughly the same as inflation, while growth in other agency budgets increased by a higher percentage.

This has resulted in continued decreases in the agency's budget as a percentage of the state's total budget:

WELFARE'S DECLINING SHARE OF STATE BUDGET FY75 - FY86

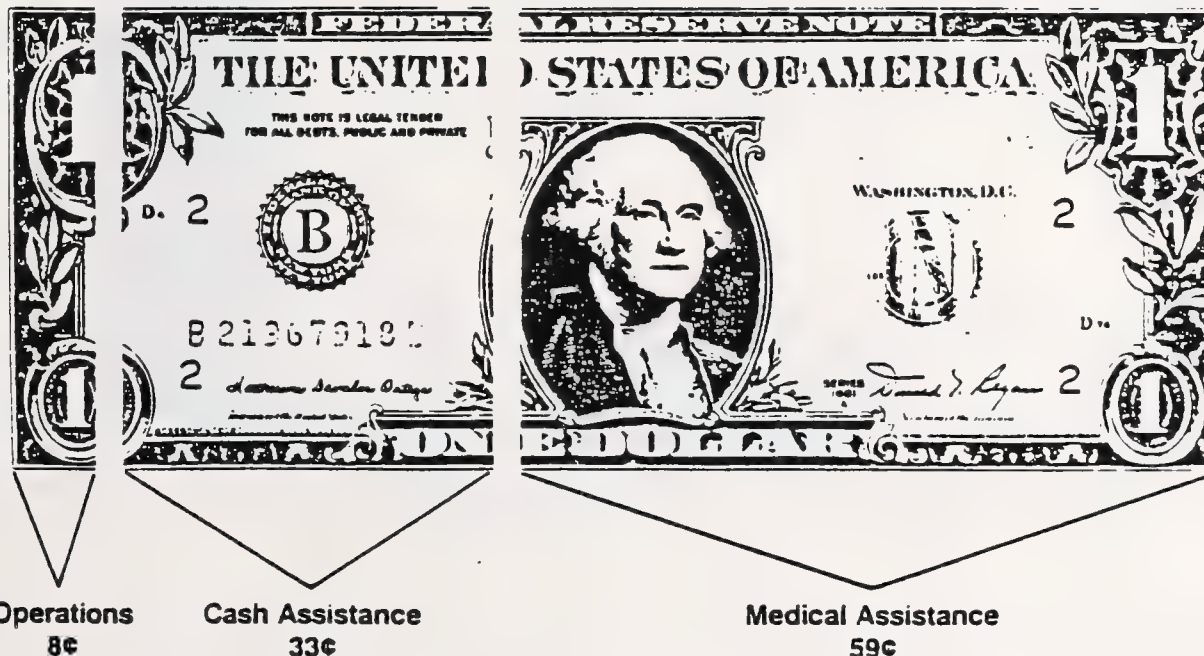
Share of state budget



These percentages have been adjusted for FY75-80
to recognize the transfer of certain activities
now performed by the Dept. of Social Services

The agency's budget goes overwhelmingly to serve clients directly: only 8 cents of every dollar the Department spends goes to the administrative cost of delivering services. This remarkably low rate of administrative overhead compares with rates of 15 to 20% in many private companies and public agencies.

THE WELFARE DOLLAR FY87

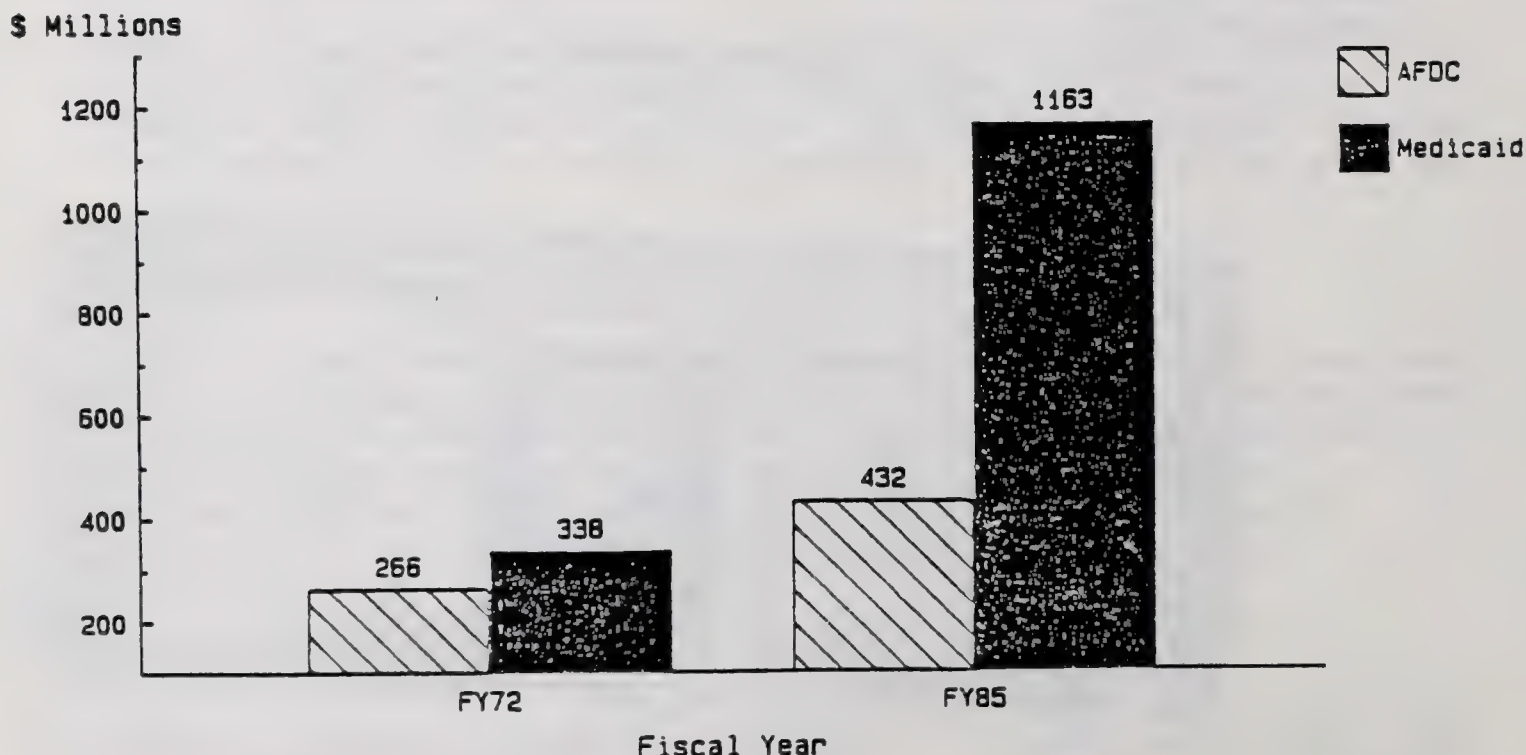


59% of Department spending goes to meet the medical needs of poor clients, through such programs as Medicaid, health services for GR clients, and continued health coverage for ET graduates. Most of these services go to serve the medical needs of the elderly, or 47% of all medical spending.

The next largest component of spending goes to children and families who receive AFDC. The graph below depicts spending trends in Medicaid and AFDC. Medicaid expenditures have increased substantially each year (an average of 10.4% annually for the FY74-83 period) until FY84, when agency savings initiatives cut growth to 2.6%. The growth in the years following FY84 is also relatively moderate, principally because of additional savings initiatives. AFDC expenditures, by contrast, actually declined for a period of several years. Federally mandated reductions in the AFDC caseload produced substantial caseload and expenditure reductions in FY82 and FY83. Beginning in FY84, the state's strong economy, the Department's Employment and Training program, and a sharp reduction in the AFDC error rate have resulted in a continued decline in the caseload. The average caseload for FY85 was the lowest in twelve years. The Department's agenda of increased benefits for clients, an agency commitment to both improving the basic cash grant and implementing initiatives (Emergency Assistance for the homeless, for example) aimed at assisting particularly vulnerable groups, has resulted in some recent increases in AFDC expenditures.

One result of the relatively disparate trends in the agency's two major programs is that medical spending, which accounted for 54% of agency expenditures in FY81, will account for an estimated 59% in FY87.

MEDICAID V AFDC SPENDING FY72 - FY85



Federal reimbursement of 50% or more is available for most of the Department's programs for a total of \$947.7 million in FY87. Since federal reimbursement occurs after the Department has made expenditures, and generally accrues to the General Fund rather than to the Department's accounts, state funds to cover all expenditures must first be appropriated in full by the legislature. Federal reimbursement ranging between 50% and 90% is available for most of the Department's administrative costs, depending on the regulations which apply to each activity.

THE STATE BUDGET PROCESS

The Department submits its initial budget request in September for the state fiscal year beginning on the following July 1. The request contains detailed recommendations for each of the Department's programs and activities. The agency submits the request to the Executive Office of Human Services (EOHS) and the Executive Office for Administration and Finance (A&F). Copies are also made available to the legislature and the public. EOHS reviews the agency's budget, using citizen input and negotiations with agency staff to determine a set of recommendations which EOHS then submits to A&F. A&F goes through a similar review process to develop recommendations for the Governor's review. A&F's part of the process includes careful consideration of the state's revenue picture. The state constitution requires a balanced budget: revenues from taxes, federal reimbursement, and other sources must be sufficient to cover spending, including local aid, agency operations, and debt service. The Governor's decisions about the budget become House 1, the administration's formal budget submission to the legislature. This submission usually occurs in late January. The state House of Representatives and the state Senate, through their respective Ways and Means Committees, review the Governor's budget proposals and hold budget hearings, which include testimony by agency staff. The House Ways and Means Committee develops a budget recommendation for review and eventual approval by the full House; the Senate Ways and Means Committee follows a similar process to produce an independent recommendation for the Senate. Interest groups and administration staff contribute their views to the process on a continuing basis. The House and Senate resolve differences between their respective recommendations in a conference committee, which produces a consensus budget for ratification by the House and the Senate. The final budget is then submitted to the Governor for review and signature, with the exception of any items he chooses to veto. The budget authorizing spending and program initiatives for the new fiscal year usually becomes final in late June or early July.

ABOUT THIS BOOK

This document provides a detailed explanation of the recommendations for the agency which are included in the Governor's budget submission to the legislature. This book also includes a discussion of each of the agency's principal programs and activities. With a few exceptions, this volume includes a separate narrative on each of the agency's program and operating accounts in order to make clear the relationship between agency

activities and their budgetary funding source. The document also includes special reports on particular issues which cut across program and account lines. Because of the increasing importance of savings and revenue activities to the Department, this budget narrative is accompanied by a separate volume which provides a detailed report on agency savings and revenue initiatives.

The table on the following page depicts agency expenditures from FY83 to FY86 (projected) and the Governor's FY87 recommendation by account.

DEPARTMENT OF PUBLIC WELFARE BUDGET FY83-FY87

PROGRAM ACCOUNTS	FY83 EXPENDITURES	FY84 EXPENDITURES	FY85 EXPENDITURES	FY86 APPROPRIATIONS	FY87 REQUEST
4400-1009 VOUCHER DAY CARE	\$0	\$3,926,273	\$8,808,574	\$18,000,000	\$21,525,152
4402-5000 MEDICAL ASSISTANCE	\$1,050,000,000	\$1,078,682,268	\$1,162,920,000	\$1,160,500,000	\$1,237,139,993
4402-5009 N.E. MEMORIAL	\$0	\$0	\$16,000,000	\$0	\$0
4402-5010 PREGNANT WOMEN HEALTH	\$0	\$0	\$0	\$6,000,000	\$0
4402-5300 MEDICAID-MENTAL HEALTH	\$23,109,192	\$27,234,509	\$37,978,000	\$45,100,000	\$53,149,653
4403-2000 AFDC	\$419,270,465	\$420,802,000	\$432,132,000	\$401,725,000	\$473,589,000
4405-2000 SSI	\$108,359,320	\$107,147,520	\$103,842,841	\$100,899,920	\$115,007,871
4406-2000 GR	\$67,051,853	\$77,280,875	\$72,381,138	\$83,407,165	\$83,193,675
4406-3000 HOMELESSNESS	\$0	\$4,832,171	\$4,738,000	\$6,913,098	\$12,505,000
4406-5000 GR HEALTH SERVICES	\$0	\$0	\$0	\$18,735,000	\$16,000,000
4407-1000 EMPLOYMENT AND TRAINING	\$6,929,763	\$7,909,687	\$3,114,486	\$3,900,000	\$20,835,560
4407-1010 GR ET	\$0	\$0	\$605,075	\$1,350,000	\$2,392,000
4407-1012 ET HEALTH	\$0	\$0	\$0	\$0	\$1,400,000
4408-2000 EMERGENCY NEEDS	\$298,192	\$0	\$0	\$0	\$0
OPERATING ACCOUNTS					
4400-0900 CONTRACT OPERATIONS	\$0	\$0	\$33,108,392	\$26,100,000	\$0
4400-0950 LOCAL OFFICE OPERATIONS	\$0	\$0	\$60,624,439	\$69,184,649	\$74,213,433
4400-0999 UNIT 8 RESERVE	\$0	\$0	\$0	\$1,000,000	\$0
4400-1000 MANAGEMENT AND SUPPORT	\$74,224,483	\$80,649,586	\$28,049,897	\$29,300,000	\$38,066,792
4400-1003 MEDICAL ADMINISTRATION	\$13,647,152	\$16,866,592	\$4,138,452	\$5,000,000	\$18,172,538
4400-1004 CHILD SUPPORT ENFORCEMENT	\$5,743,629	\$5,695,316	\$6,639,281	\$6,522,614	\$8,821,251
4400-1006 CS-SPECIAL PROJECTS	\$0	\$0	\$47,851	\$460,180	\$0
4400-1010 SYSTEMS	\$0	\$1,331,200	\$4,759,060	\$1,103,803	\$4,361,999
4400-1016 MPACS	\$0	\$0	\$14,962,157	\$0	\$18,600,000
4400-1035 TRAINING	\$612,985	\$609,966	\$574,761	\$0	\$1,738,947
4400-1200 FOOD STAMPS	\$10,887,514	\$11,143,885	\$8,412,587	\$8,691,740	\$11,465,861
4400-1400 PROJECT GOOD HEALTH	\$1,080,682	\$1,125,729	\$1,159,229	\$1,295,420	\$1,463,027
4402-5101 UTILIZATION REVIEW	\$4,937,346	\$6,428,018	\$0	\$0	\$0

*FY85 supplemental appropriation, prior appropriation continued in FY86.

INTRODUCTION TO THE EMPLOYMENT AND TRAINING PROGRAM

One year ago, on January 16, 1985, Governor Michael Dukakis delivered his state of the state address, entitled "Opportunity for All." The Governor discussed the ten years of economic recovery from 1975 to 1985. Massachusetts moved from a state that had one of the highest unemployment rates to having one of the lowest during that period.

The state's goal for the future, the Governor said, should be extending the benefits of this economic recovery to all -- all regions and all citizens. One of the centerpieces of this effort to extend opportunity to all citizens is the state's Employment and Training Choices program (ET).

A year later, in the 1986 state of the state address, the Governor spoke of the successes in extending opportunity to all. The Governor said,

"...across this Commonwealth people and communities were writing their own success stories... It's happening in Fitchburg where Doris Lupaczyk Pineo -- the mother of two small children -- made an investment in her life -- and with the help of our ET Choices program enrolled in a training course at the Montachusett Employment Training Center. Today she is an electronics technician for Hudson West in Fitchburg earning nearly \$6.00 an hour. Has her life changed? Listen to her own words:

'The door to let my family out of the trap has been lifted.'

And last November she and her new husband, a student at that same training course, were able to buy a home -- their first."

ET Choices is the Governor's program of employment and training services for welfare clients. Several state agencies participate in offering services to welfare clients, including:

- o Division of Employment Security;
- o Office of Training and Employment Policy (Job Training Partnership Act system);
- o Bay State Skills Corporation;
- o Department of Social Services; and
- o Department of Education.

By coordinating the services provided by these and other state agencies, ET Choices has expanded the opportunities available throughout the state

to welfare recipients, thus offering economic self-sufficiency as a real alternative to welfare.

ET Choices includes a substantial amount of private sector involvement. More than 6,000 businesses have hired ET clients since the program's inception, and the amount of business support continues to grow. It is the unique combination of private sector involvement, local office performance standards, collaboration between state agencies, and a choice among program options that have created the success of ET Choices.

ET PERFORMANCE

Since ET Choices began operating on October 1, 1983, the program has:

- o Placed 23,000 AFDC clients into jobs.
- o Provided jobs with average full-time wages of \$10,100 per year, or double a welfare grant.
- o Attracted more than 6,000 businesses to participate, from high tech manufacturers to small retail stores.
- o Saved the Commonwealth \$69 million.

However, while these statistics indicate the success of ET Choices, they do not measure the full impact of the program -- its impact on the lives of thousands of welfare recipients for whom economic independence has become a reality. As the Governor said in his 1985 state of the state address,

"I have met with dozens of our ET participants, and the change in their sense of self-worth and self-esteem, in their feelings about themselves and their futures, is a wonderful thing to see and experience."

OPPORTUNITY FOR ALL: FURTHER CHALLENGES

In order to ensure that opportunity is available for all, ET has expanded its successful program model to include participation by other welfare clients. Specifically, the ET program has:

- o Placed more than 800 General Relief clients into employment through the GR Employment and Training Program;
- o Assisted in the development of a Refugee Education and Employment Program, which has placed more than 2,000 Refugee clients into jobs.
- o Funded training and job placement services for more than 200 ex-offenders who found jobs through the Comprehensive Offender Employment Resource System.

- o Expanded on-the-job training programs for emotionally disabled clients through a Supported Work program with the Department of Mental Health. 240 individuals will be served through June 30, 1986.

The sections which follow provide a description of the ET and GR ET programs as well as a detailed discussion of the program's performance to date and its expansion to include more welfare clients. The ET agenda for FY87 is also discussed. Specifically, this agenda includes:

- o literacy, basic education, and English as a Second Language and General Educational Development preparation to reach longer term welfare clients;
- o employment and training services to new welfare populations-- General Relief clients, youth, minority and disabled clients;
- o development of a collaborative effort with several state agencies for a comprehensive approach to youth services;
- o a more comprehensive package of services to support ET participants, including voucher day care, transportation reimbursement and health insurance coverage.

As ET moves into its third year, it offers a larger array of services and targets longer-term, harder to serve welfare clients. The agenda for FY87 reflects these changes, as the Department moves closer to the goal of offering real alternatives and opportunities for all.

THE ET PROGRAM

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures	\$15,484,000*	\$18,487,000*	\$27,380,000*	\$34,235,000*
Job Placements	6,040	11,089	8,000	10,000

One of the Department's top priorities is to give public assistance recipients the opportunity to become self-sufficient by helping them to obtain jobs that will enable them to support themselves and their families. Since the Employment and Training (ET) Choices program began in October 1983, more than 23,000 Massachusetts recipients of Aid to Families with Dependent Children (AFDC) have obtained full or part-time jobs. The success of the ET program is based upon the philosophy that welfare recipients should have the same employment opportunities available to other people, and that they will make use of those opportunities if necessary support services are available. Therefore, ET Choices is designed to assist participants in overcoming identifiable barriers to employment by providing skills training, education, direct job placement, day care and transportation.

Through January 1, 1986, ET Choices has placed 23,048 individuals into employment, a placement rate that is 44% above the goal established at the beginning of the program. These placements have contributed to the decline in the AFDC caseload, which for FY85 was the lowest it had been in over twelve years. ET job placements have also contributed to the Department's savings and revenue agenda. Since the program's inception, ET has resulted in \$69.1 million in savings from recipient grant reductions and case closings. Thus, ET Choices offers benefits to participants, in the form of economic independence, and to the Commonwealth's taxpayers, in the form of savings in public assistance costs.

The achievements of the ET program are attributable to several factors:

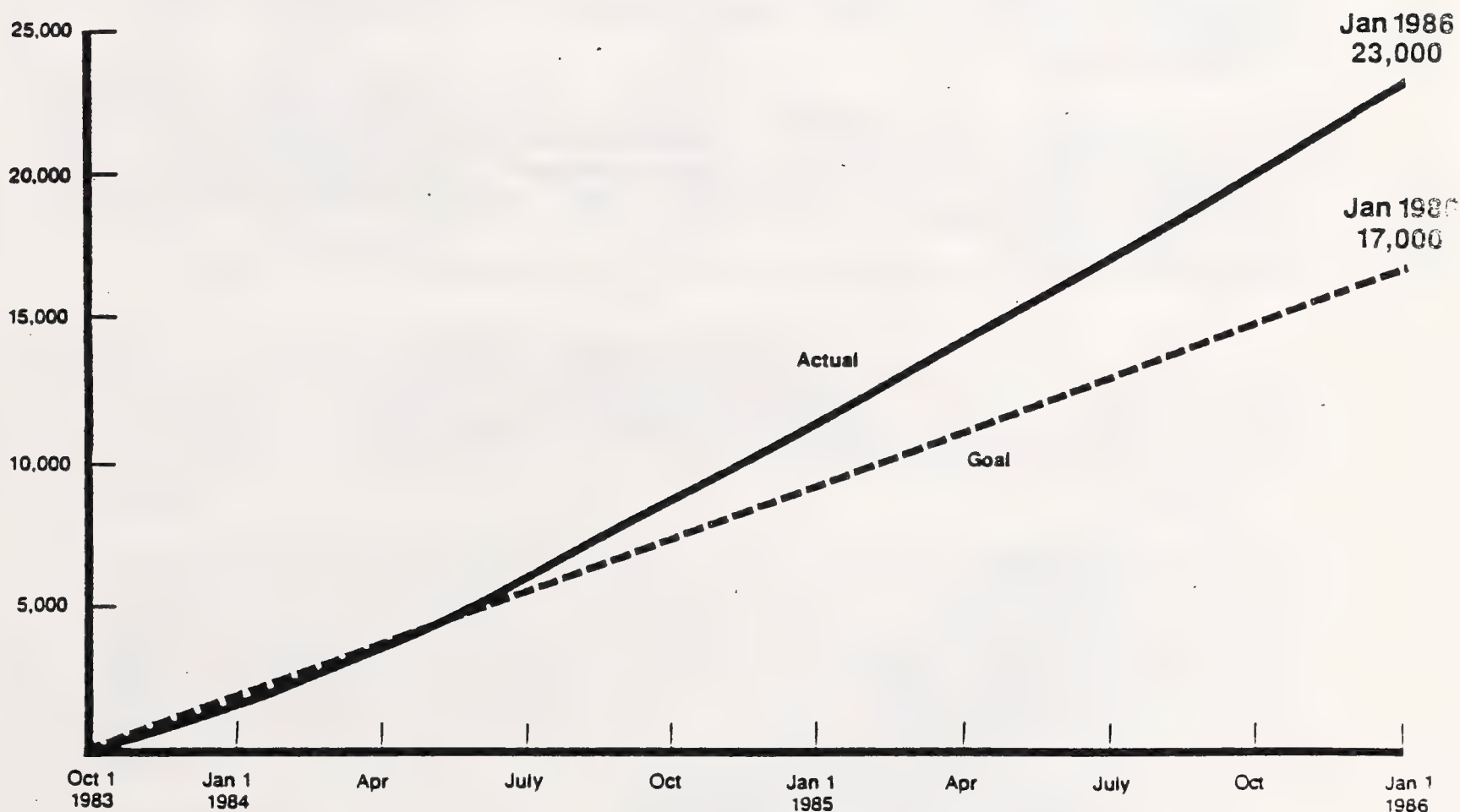
- o client choice in determining the most suitable employment program;
- o management initiatives, including local office accountability and performance-based provider contracts;
- o program options that vary to meet the diverse needs of clients;
- o support services, such as day care and transportation; and

*Does not include Voucher Day Care expenditures of \$5,075,000 in FY84, \$8,808,000 in FY85, \$18,000,000 in FY86 and \$21,525,152 requested in FY87.

- o close and effective cooperation with other state agencies, especially the Division of Employment Security, Office of Training and Employment Policy, Bay State Skills Corporation and the Department of Social Service.

These factors have led to high placements, wages and job retention rates, which translate into economic independence for thousands of welfare recipients. The FY87 goal of 10,000 new placements builds on the success of 6,040 placements in FY84 and 11,089 new placements in FY85. Placements through the first 6 months of FY86 total 5,919, or 74% of the goal for the year. The chart below compares actual placements to the placement goal.

MONTHLY ET JOB PLACEMENTS: ACTUAL VS. GOAL



PERFORMANCE

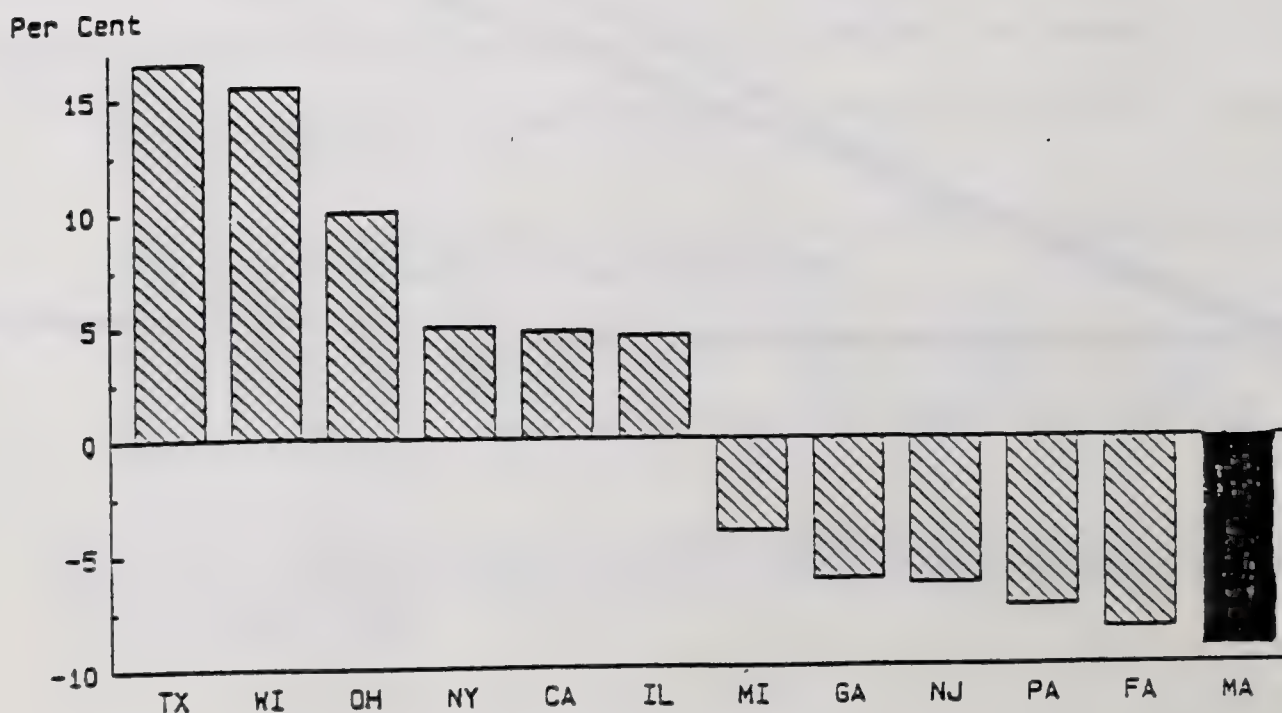
The goal of ET Choices is to offer meaningful employment and economic self-sufficiency as realistic alternatives for AFDC recipients. Since the program began in October 1983, ET has achieved significant results:

- o ET participants were placed into unsubsidized, private sector employment in more than 6,000 companies and businesses located throughout Massachusetts;
- o 75% of ET participants were placed into full-time employment at an average starting wage of \$10,100 per year, or more than twice the welfare grant that previously supported their families;
- o 75% of full-time placements received employer-sponsored, private health insurance; and
- o 86% of clients who leave the AFDC caseload due to an ET job are still off the caseload one year later.

These statistics suggest that AFDC recipients leave the ET program prepared to enter employment, and that job placements are matched as closely as possible with each individual's education, training and employment goal.

The successful job placement record of ET Choices has contributed significantly to the decline in the Massachusetts AFDC caseload. While the AFDC caseload of the top twelve caseload states increased on average by 2.5% from January 1983 to July 1985, Massachusetts' AFDC caseload declined by 9.4%.

AFDC Caseload Change
Top 12 Caseload States
January 1983 to July 1985



As shown in the preceding chart, the decline in the Massachusetts caseload from January 1983 to July 1985 was higher than that of any of the top twelve welfare states.

During the same period of time, the unemployment rate dropped in all the twelve states shown. In fact, in five of these twelve states, the unemployment rate dropped more than in Massachusetts, yet the respective AFDC caseloads did not decrease nearly as much as in Massachusetts.

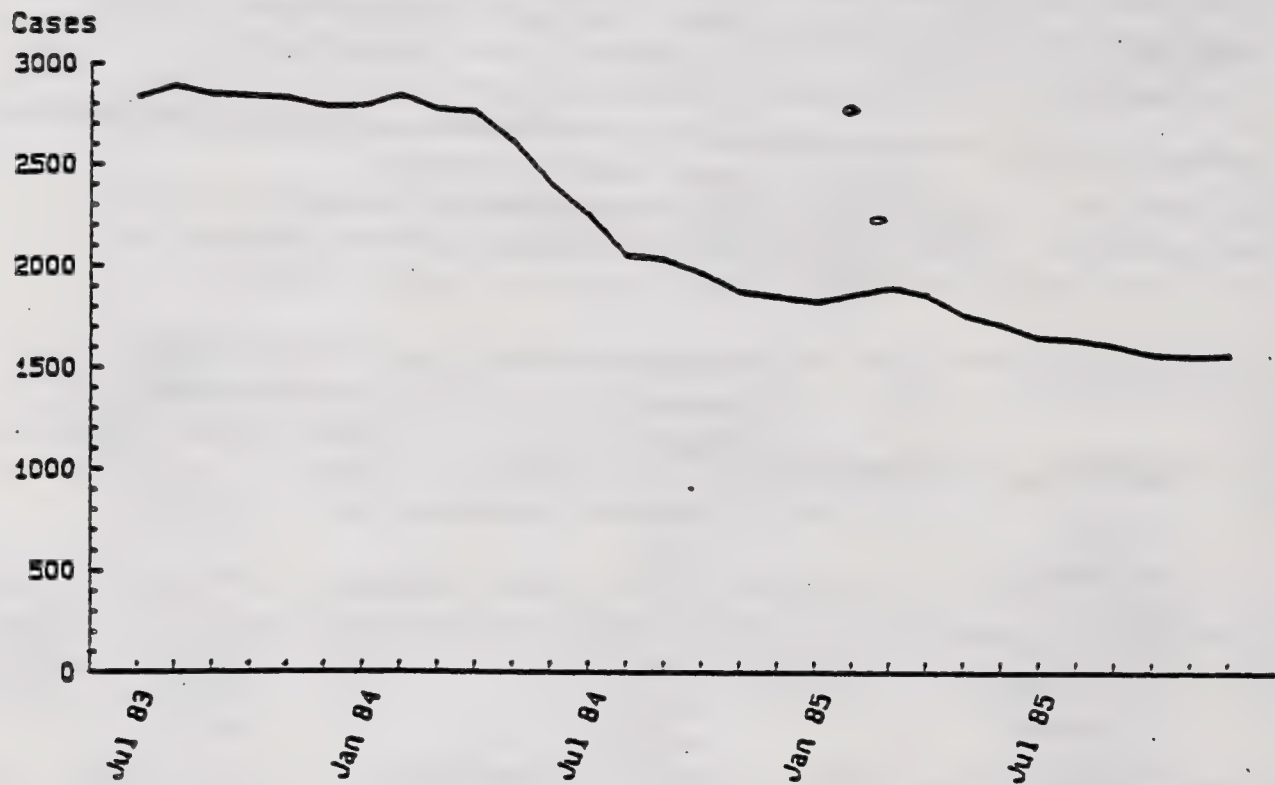
**Twelve Largest Welfare States
AFDC Caseload and Unemployment Trends
January, 1983 to July, 1985**

<u>State</u>	<u>AFDC Caseload Change</u>	<u>Unemployment Rate Change (percentage points)</u>
Texas	16.6%	-0.8
Wisconsin	15.6%	-6.8
Ohio	10.1%	-5.6
New York	5.0%	-3.5
California	4.8%	-4.0
Illinois	4.6%	-4.6
Michigan	-4.2%	-6.2
Georgia	-6.3%	-1.0
New Jersey	-6.5%	-3.0
Pennsylvania	-7.5%	-7.1
Florida	-8.5%	-3.4
Massachusetts	-9.4%	-4.4

A strong economy in and of itself is not sufficient to result in a large decrease in AFDC rolls, as the preceding chart shows. Clearly, other factors influence the level of the AFDC caseload. In Massachusetts, ET Choices has become one of the primary factors leading to the caseload decline.

ET has been particularly effective in helping two parent families who qualify for AFDC through the Unemployed Parent program (UP). Because UP cases are often headed by men with recent employment histories, these families have been particularly likely to benefit from the ET program. As indicated in the following chart, within five months of implementation of ET in October 1983, the UP caseload began to decline and has continued to decline since then.

Unemployed Parent Caseload FY84 - FY86



The decline in the UP caseload illustrated above is directly related to activity in the ET program. In the first quarter of FY85, men comprised 38% of all clients placed into employment through the Division of Employment Security, although men represented just 4.7% of the AFDC caseload at that time. The proportion of male AFDC clients serviced by DES dropped a year later to 29%, and is expected to continue its decline. This demographic data suggests that a high percentage of job-ready clients participated in ET Choices during the first two years of the program. The challenge in the future, therefore, will be in providing an appropriate mix of services to attract longer-term, less job-ready clients. Indeed, the FY87 ET request reflects a shift in focus toward more clients who are more difficult to serve in that they need extensive education and training before they can obtain the type of employment that leads to economic self-sufficiency.

The emphasis of the FY87 ET request is on basic education and expanded services to new client populations. The request will allow ET to attract 30,000 participants and place 10,000 AFDC clients into jobs. FY87 will build on the program's performance in the first 27 months. The 23,000 AFDC clients who found employment through ET Choices in this period were not placed into "dead-end" subsidized positions, an assumption that is often made about AFDC employment programs. Rather, the full-time wage received by ET placements indicates that educational and vocational preparation has real economic benefits. Specifically, the most recent data from participating state agencies includes the following:

- o Division of Employment Security placements provide full-time wages averaging \$5.30 per hour. Thirty days after placement, the average full-time wage increases to \$5.49 per hour.
- o Job Training Partnership Act wages average \$5.64 per hour.
- o JTPA wages in metropolitan Boston average \$6.07 per hour.
- o Bay State Skills Corporation wages average \$6.13 per hour.

.. The chart on the following page shows the distribution and wages for Division of Employment Security ET placements as compared to all individuals who find jobs through DES.

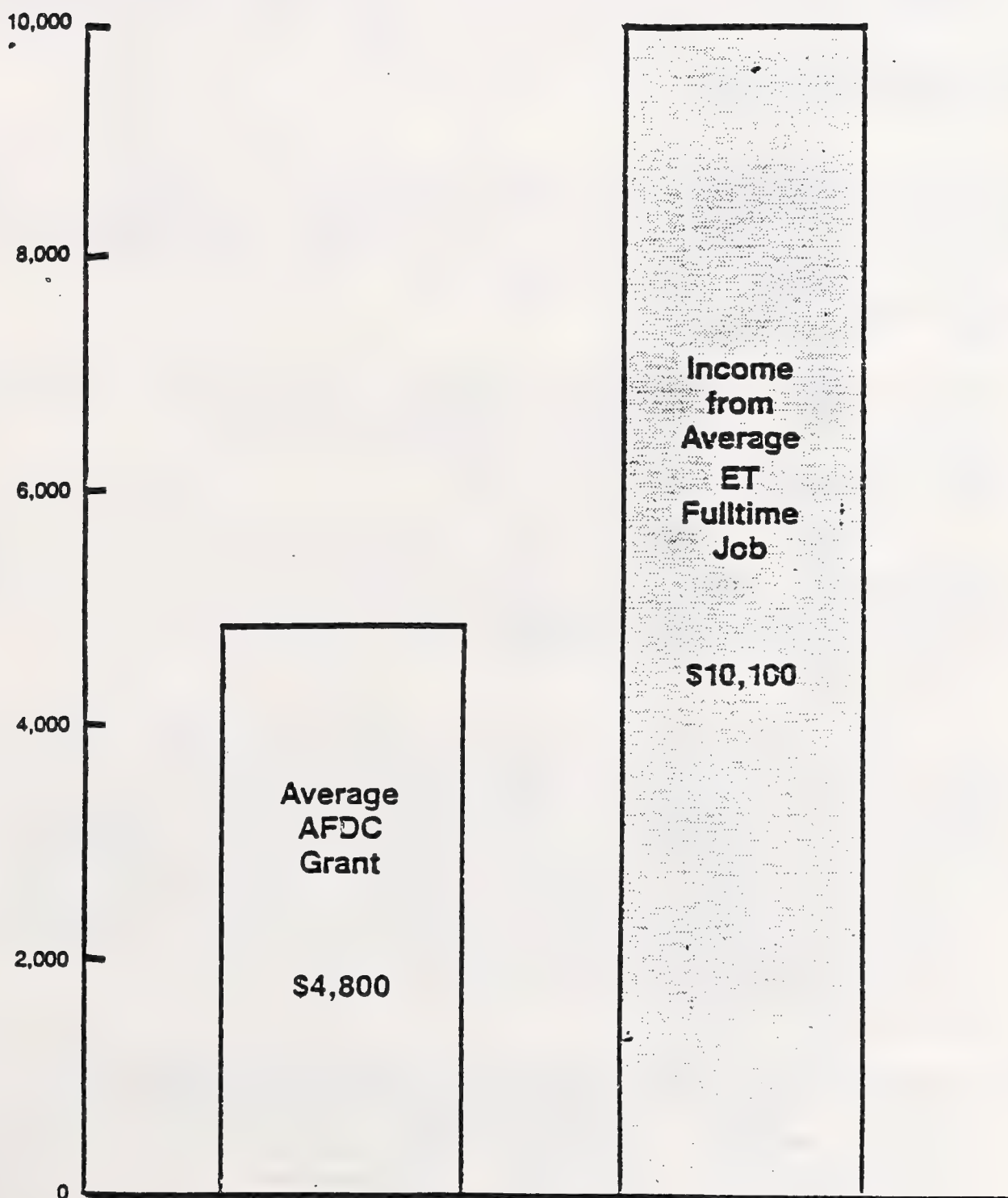
**ET FULL TIME PLACEMENTS
COMPARED TO ALL JOBS BY
PERCENTAGE AND HOURLY WAGE
July 1, 1985-Dec. 1, 1985**

<u>ET CHOICES*</u>		<u>Occupation</u>	<u>All Job Placements</u>	
<u>Average Hourly Wage</u>	<u>Percentage of Jobs</u>		<u>Average Hourly Wage</u>	<u>Percentage of Jobs</u>
\$4.41	2%	Farming, Fishing, Forestry	\$3.89	5%
5.10	2	Processing	4.32	4
6.63	3	Transportation	6.77	3
4.83	4	Sales	3.74	10
5.82	6	Machine Trades	5.30	3
6.88	7	Construction	6.24	5
4.68	8	Benchwork	5.01	5
7.33	10	Professional/Managerial	7.79	3
4.67	12	Packing/Handling	4.27	21
5.16	18	Service	3.95	22
5.28	28	Clerical	4.37	19
5.49	100	Total	4.50	100

Note: Placements represented are from Division of Employment Security Job Development and Placement Services only; wage rates are taken at 30 days after placement.

Overall, the average ET full-time starting wage is \$5.18 per hour, which translates into \$10,100 in yearly income. Since the average AFDC recipient receives a grant of \$4,800 per year, a full-time job obtained through ET means a 110% increase in yearly income, as illustrated in the following chart.

INCOME: WELFARE VS. WAGES, 1985



ET SUCCESS STORIES

While the preceding chart illustrates the economic advantages of ET participation, it does not measure the full impact of ET: its impact on the lives of thousands of welfare recipients for whom economic independence has become a reality.

- o Ruby Sampson and her three children had been on welfare for 14 years. In September 1985, Ruby completed a 44-week ET training program for operating room technicians where she studied anatomy, physiology, medical terminology, and surgical procedures. Today Ruby is employed at the Brigham and Women's hospital earning more than twice what she received on welfare. Ruby has plans to continue her education while she works and to buy a home one day. Ruby has found "an excellent career and our hospital has a highly skilled operating room technician," according to Dr. H. Richard Nesson, President of Brigham and Women's Hospital.
- o The Bristol Knitting Mills, a sweater manufacturer in Fall River, has hired four graduates of an ET Supported Work program. Edward McLaughlin, vice president of manufacturing for Garland Corporation, Bristol Knitting's parent company, says the firm could use more employees like the four ET graduates. "These people really want to work," he affirmed.
- o Winnie Santiago had been on welfare for six years. She is now employed at AT&T in North Andover, working as an electronic assembler. Winnie found her job after enrolling in an ET Choices skills training course in Lawrence.
- o Brenda Parker, an AFDC mother of three children, was able to find a job with the help of day care services provided by the ET program. Now employed as a cutting machine operator at Esleeck Paper Company in Turner Falls, Brenda makes twice the amount she received on welfare and will soon be eligible for a raise.
- o Dawn Lawson and her son were on welfare for six years. After completing an ET training program in Worcester, Dawn landed a full-time job with the Norton Company as a word processor. While working for Norton company, Dawn has filled in for the secretary of the firm's top executives. "That is not a job we would turn over to someone who ins't top notch," observed Thomas J. Hourihan, Vice President for Human Resources at the Norton Company. Since Dawn started working at the Norton Company she has been able to move out of public housing, buy her first car, and take her son on a vacation on the Cape.
- o Sandra Risner, the mother of two daughters, began a seven month ET training program in the field of computer electronics after nearly 10 years on welfare. Sandra now works for Wang Laboratories in Lowell as a customer service engineer, where she earns more than three times her welfare grant. "We've got a business to run and we hired Sandra Risner because she was well trained and wanted to work," said Raymond C. Cullen, Jr., Senior Vice President for Marketing Services at Wang Laboratories.

FY87 AGENDA

The ET placement goal for FY87 is 10,000 new job placements. Attaining this goal will generate \$30 million in additional AFDC grant and Medicaid savings and \$1.4 million in new taxpayer revenue. Emphasis on wage rates and job retention will continue in FY87 to ensure lasting self-sufficiency for clients who obtain jobs through ET.

The 30,000 AFDC clients who participate in ET in FY87 will be longer-term, less job-ready clients. The challenge for FY87 is to meet the needs of clients who are more difficult to serve. They will need more basic education and training before moving into employment that leads to economic self sufficiency.

The FY87 agenda balances the goal of 10,000 placements, increased wages, and job retention rates with these needs in the following strategy:

- o Continuation of basic ET programs: career planning, on-the-job training through supported work, skills training, and job placement.
- o Expansion of programs for less job-ready clients, including basic education, English as a Second Language, General Education Development and literacy programs.
- o Implementation of a comprehensive youth program that will offer:
 - drop-out prevention
 - coordinated services for pregnant and parenting teens with emphasis on education and training
- o Development of an ET health insurance program to increase job retention and ease the transition to self-sufficiency.
- o Continuation of the management strategies, such as local office placement goals and performance contracting for vendors, which have been critical to the successful performance of ET to date.

A. Basic Education

In FY87, ET will implement a strategy for attracting and serving longer-term AFDC clients whose first step toward meaningful employment must begin with basic education. This strategy involves a substantial increase in educational options available in ET Choices, including remedial and tutorial programs, basic education and English a Second language. Specifically, the FY87 plan proposes:

- o An increase in adult literacy and basic education funds from \$2.7 million in FY86 to a proposed \$5.1 million in FY87.
- o Full implementation of a literacy initiative developed with the Department of Education (DOE).

The DOE initiative will involve three areas. First, the Department will extend and supplement existing literacy programs. Department funds would be used for instruction in literacy skills needed for employment, such as comprehension of job applications and resume writing. Clients will be better prepared for employment upon completion of enhanced literacy courses.

Second, the Department will expand DOE's existing capacity for the provision of General Educational Development courses, examinations and certifications. Department funds would both increase the time available for instruction and increase the service level for welfare clients.

Finally, the Department will fund additional programs in English as a Second Language.

By focusing increasingly on clients who need intensive basic education before they move into other ET programs, ET would:

- o attract clients who are longer-term welfare recipients
- o encourage participation by new client populations ..

B. Comprehensive Youth Services

In FY87, the Department proposes to implement a comprehensive program of youth service that will offer:

- o drop-out prevention; and
- o services for pregnant and parenting teens.

The youth program will address the problem of teenagers who drop out of school, do not have adequate skills training, and therefore do not have the means for being economically self-sufficient in adulthood. Indeed, high school drop-outs are 3 and 1/2 times more likely to be poor than high school graduates.

Most high school drop-outs are girls, who usually leave school because of pregnancy. These single teenage mothers experience a disproportionate rate of poverty. 29% of all children born in 1984 to a mother under the age of 19 had been on the AFDC caseload by November 1985. Moreover, there is a relationship between teenage pregnancy and persistent welfare dependency. Of all AFDC single female parents under age 35, roughly 50% gave birth to their first child while under age 19. In contrast, of all Massachusetts first-time mothers under age 35 in 1983, only 17% were under age 19.

These statistics indicate a relationship between teenage pregnancy, poverty, high school education and welfare dependency. The ET program will offer the following services in an effort to address this significant problem.

o Drop-Out Prevention

The youth drop-out prevention program will provide services to junior high school age children who are at risk of leaving school. Career planning, vocational counseling and remedial education programs will encourage these children to see the value of education, while supervised internships will introduce them to the world of work. ET will work closely with the Department of Education to implement the drop-out prevention program, serving approximately 500 youth at a cost of \$500,000.

o Pregnant Teenagers and Parenting Teens

The Department of Public Health provides medical services for low income pregnant or parenting teenagers. The ET program will enhance existing DPH services so that education and skills training can be offered to participating teenagers. Lack of vocational and educational opportunities was cited by the Governor's Alliance for Families Task Force on Pregnant and Parenting Teens as a major barrier to economic independence for parenting teens. The ET/DPH effort will merge existing health services with needed vocational programs to offer participants economic independence as an alternative to poverty. Approximately 1,000 youth would be served at a cost of \$500,000.

The second aspect of the parenting teens program includes services provided through the JTPA system. This initiative will offer pre-vocational training, vocational counseling, basic education, skills training and job experience. Approximately 321 youth will be served at a cost of \$1 million.

C. ET Health Choices

A third component of the ET FY87 agenda is the establishment of an ET Health Choices program. ET participants, while on AFDC, receive a comprehensive package of primary and acute health care benefits through the Medicaid program. However, clients who leave the caseload due to ET will lose these Medicaid services. If health insurance is not available through the client's employer, the individual may find it impossible to remain employed due to the high cost of health care. To assist these clients in the critical first year of employment the Department has developed an ET Health program. The FY87 request includes funds to guarantee one year of continued health coverage for up to 2,250 ET participants who do not receive coverage in their jobs.

The proposed ET Health Choices program would complement the Department's voucher day care program, which makes day care services available to ET graduates in the critical first year of employment. Combined, these efforts reflect the Department's continuing commitment to provide the support services necessary to make long-term employment a viable alternative to public assistance.

D. Program Management

Several management initiatives, which have had a significant role in the program's success, will continue in FY87.

o Local Office Accountability

The ET program developed local office goals to establish management accountability in each welfare office. These goals specify the number of reappraisals, referrals, and job placements for which each local office, and therefore each ET worker, is responsible. This management accountability system has connected the work of local office ET staff directly to the program's performance goals.

o Performance-Based Contracting

The ET program also developed performance-based contracts with ET providers and instituted a contract management system. Contracts and interagency agreements include specific performance goals, which ensure that vendors are paid only when performance requirements are met.

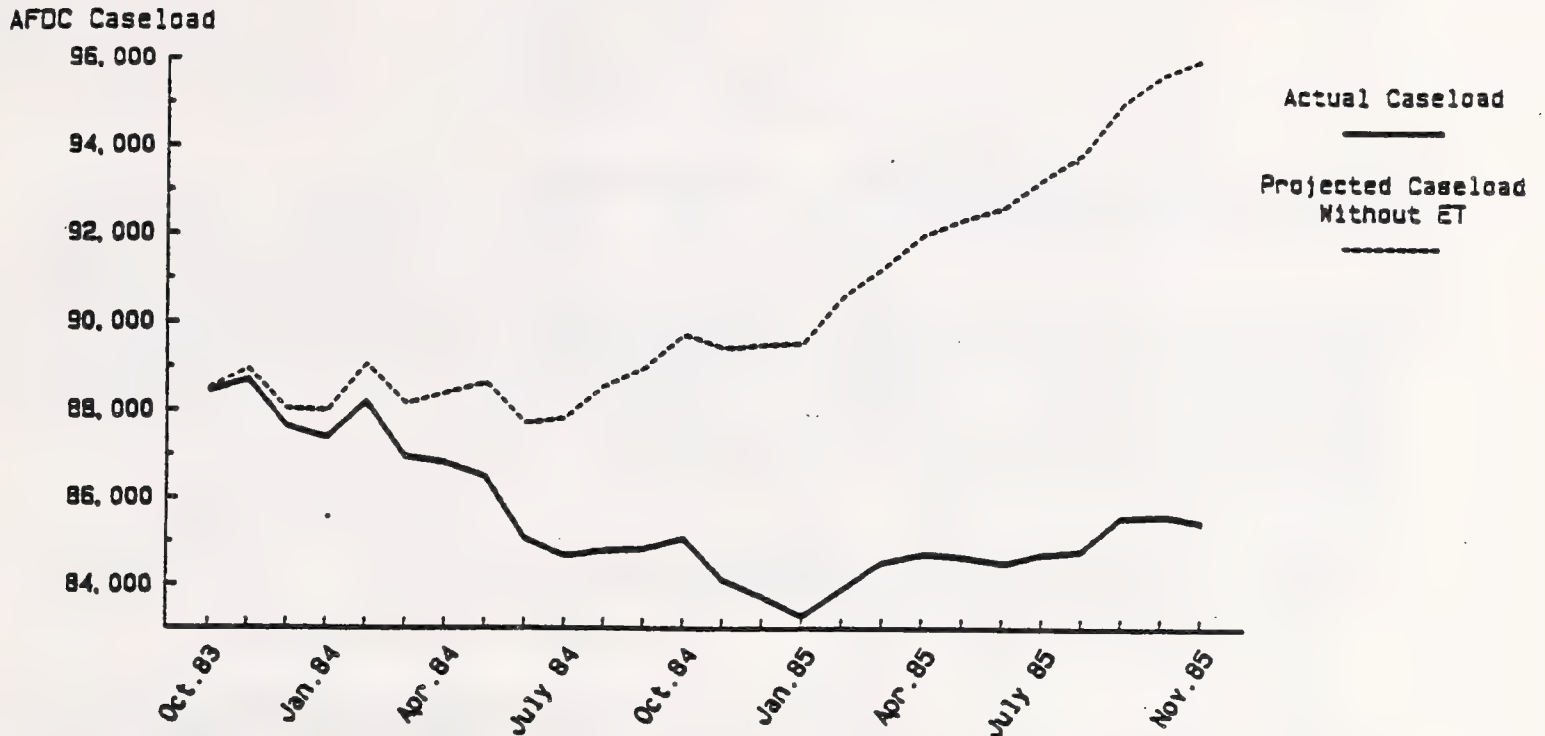
o Savings

Since October 1, 1983 more than 23,000 AFDC recipients have been placed into full or part-time jobs at a total cost of \$71 million. The average cost per ET placement is therefore approximately \$3,100. The typical AFDC case in Massachusetts cost \$6,100 per year --\$4,800 in a cash grant and \$1,300 in Medicaid services. The cost of maintaining 23,000 AFDC cases for a single year would therefore total \$140 million. Thus, by placing 23,000 recipients into jobs, ET has saved some \$69 million. In FY87, net ET savings will be \$30 million.

o Caseload Impact

As discussed previously, the ET program has become one of the primary factors leading to the caseload decline. With the assistance of the ET program, the AFDC caseload is significantly lower today than it would have been without ET. The AFDC caseload in November, 1985 would have been 95,945 compared to 85,411 were it not for ET. The following chart summarizes this caseload information.

EFFECT OF ET ON THE AFDC CASELOAD



o Tax Revenue

When an AFDC client leaves welfare due to an ET job, the client benefits through the resulting economic independence, and the Department benefits through grant savings and a decrease in the AFDC caseload. However, the effects of ET employment extend beyond the Department, for ET graduates generated additional tax revenue for the Commonwealth. It is estimated that \$13.5 million in additional revenue will result from ET placements between FY84 and FY89.

PROGRAM DESIGN

ET is designed to encourage participation by thousands of AFDC recipients who have diverse needs. To attract these clients the program has implemented a marketing campaign that coordinates direct mailings, newsletters, posters, brochures and community events. The marketing campaign encourages clients to enroll in ET by describing the successes of former recipients who have moved off of welfare and out of poverty. It is the reality of these successes that motivates other welfare clients. The marketing campaign, which communicates these success stories to all AFDC recipients, is a vital part of ET Choices.

Although all AFDC clients are encouraged to participate in ET, certain recipient groups are targeted for participation. These target groups are:

- o principal earners in two-parent families;
- o women with children between the ages of 14 and 18;
- o teenage dependents;
- o pregnant teenagers and teenage mothers; and
- o other volunteers.

With the assistance of an ET worker, each ET participant develops an Employment Plan that outlines an employment goal and the steps necessary to reach that goal. Participants may choose to enroll in one or more components, as outlined in the Employment Plan, in preparation for long-term employment. The components are:

- o career planning;
- o on-the-job training through supported work;
- o education and training; and
- o direct job placement.

An AFDC recipient may enter the ET system through several routes. As a regular part of the AFDC application process, many applicants are required to register with ET. As part of the regular redetermination process that the Department conducts to ensure continuing eligibility and accuracy of benefits, the caseworker has another opportunity to encourage clients to participate in ET. Finally, a client may contact a local welfare office to participate in ET in response to the program's marketing campaign. Intake and registration are handled by the client's Financial Assistance Social Worker, who then refers the client to an ET Worker for appraisal.

The ET worker interviews the registrant to determine the individual's education and employment background, potential for employment, and need for support services. The ET worker explains each of the program options and assists the client in choosing the component that will best serve the goal of obtaining employment for the client. The result of this process is the recipient's employment plan. The following chart illustrates the program alternatives that are available and the flow of services that assist individuals in securing employment.

ET participants may choose to enroll in one or more program options in preparation for their employment goal. The ET components are:

A. Career Planning

Career planning is the first option for many ET participants. Career Planning, through contracts with individual vendors, offers skills testing, evaluation, and career guidance for clients who need assistance in establishing a specific training plan. Once an assessment has been completed, the ET participant is prepared to enter one of the other ET components. Thus, career planning ensures that ET training funds are used for those clients who have the interest and preparation to continue through the ET system. In FY86, ET implemented a career planning model, through contracts with JTPA and private vendors, which standardized career planning services and established performance-based payments. In FY85, 6,221 ET participants received career planning services before enrolling in one of the other ET components.

B. On-the-Job Training through Supported Work

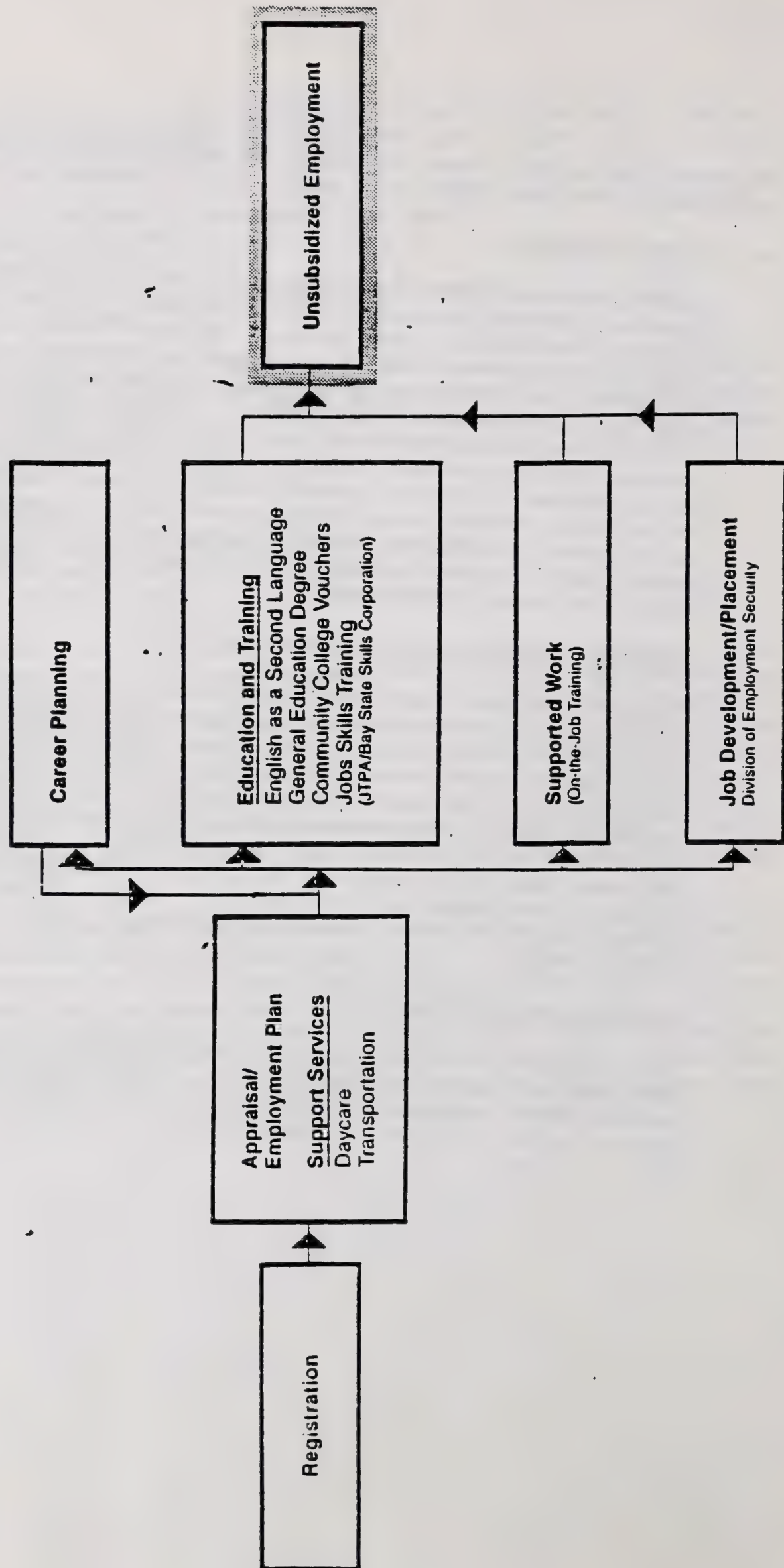
The supported work component is designed for ET participants who have little recent work experience and a sporadic employment history. ET contracts directly with supported work vendors, who place participants into worksites where they gradually move into full-time employment. The supported work program stresses graduated responsibilities, peer support and close supervision, so that the transition to self-sufficiency is successful. Between October 1, 1983 and January 1, 1986, 3,765 participants were served and 1,894 graduated from supported work into full-time employment. The average hourly wage for these placements increased from \$4.79 in FY84 to \$5.04 in FY85.

C. Education and Training

The education and training component provides the largest array of services available to ET clients. Participants may choose the program most appropriate for their specific employment goal. The choices in education and training are:

ET CHOICES

FLOW CHART



o Job Training Partnership Act (JTPA) System

The ET program contracts with the JTPA administrative agency, the Executive Office of Economic Affairs (EOEA), to increase the number of welfare recipients served by JTPA. The JTPA service delivery system offers traditional skills training in occupations such as office services, electronic technology and assembly, and machine trades. Between October 1, 1983 and September 1, 1985, 1,577 ET participants enrolled in JTPA skills training programs through the JTPA/Welfare Agreement. 644 of these individuals entered employment upon completion of their training courses, 128 completed pre-vocational programs and entered other programs, and 300 remain in JTPA services. The average hourly wage increased from \$4.98 in FY84 to \$5.32 in FY85.

An additional 4,930 AFDC clients were served with JTPA federal funds between October 1, 1983 and September 1, 1985. 1,502 of these participants were placed into employment through September 1, 1985.

o Bay State Skills Corporation (BSSC)

The Bay State Skills Corporation also offers training programs in traditional occupations. The ET program contracts with BSSC, which then awards contracts to several training vendors. Between October 1, 1983 and January 1, 1986, 784 ET participants enrolled in BSSC training courses. 386 of these individuals entered employment and 22 entered higher education. The average hourly wage for these placements increased from \$5.48 in FY84 to \$6.11 in FY85 and is currently \$6.56 per hour.

The Bay State Skills Corporation also offers a displaced homemakers program for women who have been out of the job market for many years while raising their families. Displaced homemakers lack both the employment history and necessary skills for re-entry into employment. The BSSC program is a feeder program which prepares participants to enter other skills training. Again, the ET program contracts with the BSSC, which then awards contracts to vendors for specific services. Between October 1, 1983 and September 1, 1985, 1,229 ET participants served in BSSC displaced homemaker programs.

o College Voucher Program

The ET program contracts with the administrative agency responsible for the state's higher education system, the Board of Regents, so that ET participants may register for college courses. Participants may enroll in one or two college courses in preparation for their employment goal. Examples of courses taken by ET clients include accounting and real estate. In FY85, approximately 2,100 clients enrolled in courses at the state's community colleges and universities.

o Other Education and Training Courses

The ET program has found that many ET participants lack basic education which may be necessary for entry into skills training. For participants who are in need of pre-vocational assistance, the ET program offers Adult Basic Education, English as a Second Language and General Equivalency Degree courses. The ET program contracts directly with education vendors who offer innovative education and training programs. Participants who choose these services are those whose needs cannot be met in more traditional classroom programs. Examples of these programs include training courses with on-site day care, literacy courses, and training courses with bilingual staff. Between October 1, 1983 and January 1, 1985, 2,645 ET participants were served in education and training programs funded directly by ET.

D. Direct Job Placement

The ET program contracts with the Division of Employment Security (DES) for job search and job placement activities. Division of Employment Security staff are often located at local welfare offices so that ET participants may be referred directly to them. Between October 1, 1983 and January 1, 1986, 12,191 ET participants entered employment through the DES program. Roughly 73% of full-time placements received employer-sponsored health insurance. The average starting wage for DES full-time placements increased from \$5.00 per hour in FY85 to \$5.30 per hour in FY86.

E. Support Services: ET Health, Voucher Day Care, Transportation

The goal of ET Choices is to provide services that lead to economic independence for clients. However, while leaving welfare results in higher earnings and enhanced self-esteem for recipients, it also results in the loss of other key services available to those on welfare. Health insurance and day care are the two most important and are major concerns for clients.

Recipients who leave the AFDC caseload due to ET employment quickly lose eligibility for Medicaid services. Former recipients may find that health care is not available through their employers, or that the cost of their employee premium is prohibitive. Health insurance is costly, and loss of Medicaid is a significant obstacle facing recipients who strive for economic independence. Roughly 25% of clients who find jobs through ET need assistance with medical coverage.

The ET Health Choices program would ensure continuing comprehensive care coverage through one of several means, including either purchasing enrollment in a coordinated care plan, such as a health maintenance organization, or contributing an equivalent amount toward the purchase of traditional health insurance coverage for families who do not receive coverage through their employers. Because

coordinated health plans promote the provision of comprehensive care in a cost-effective fashion, the Department will encourage families to enroll in some form of coordinated health plan. In developing this initiative, the Department hopes to work with private insurers and community organizations which are now examining the feasibility of operating special coordinated health care plans for low-income families. However, it is not the Department's intent to discourage employers from providing comprehensive health care coverage to ET participants; employers are legally obligated to offer the same set of health benefits to all comparable employees. Rather, the Department will assist those clients for whom health care is unavailable, so that the transition to full-time employment can be made.

Clearly, the cost of health care is a formidable obstacle for AFDC recipients who seek economic self-sufficiency. Yet another barrier exists in the cost and availability of day care.

Child care is expensive. In FY87, the average cost of day care will be \$2,800 per year. For a child with special needs or for infant/toddler care, the cost can be as high as \$5,000 annually. For the average ET graduate who earns \$10,100 per year, these costs make self-sufficiency impossible to maintain.

Day care has thus become an integral part of the ET program. 35% of ET participants have at least one child under the age of six. These clients are exempt from participation, yet choose to enroll in ET regardless of their registration status. For these clients, participation would be impossible without child care services. Thus, day care enables thousands of AFDC clients to enroll in ET programs.

However, while it provides vital support during ET participation, the availability of day care is equally important during the first year of employment. Recently employed clients will be forced to return to public assistance due to the high cost of child care if subsidized day care is not available.

The Department is committed to removing this barrier by making child care accessible and affordable. The FY87 voucher day care request reflects the growing need for quality day care services, providing day care both to AFDC recipients while they participate in ET services and to ET graduates during the first year of employment.

The third support service offered to ET participants is transportation reimbursement. Transportation reimbursement of up to \$10 per day is available for all ET participants. This reimbursement includes the cost of transporting children to and from child care, and applies both to public and private transportation.

Clients have varied transportation needs. Career planning participation may involve a single visit to a vendor, but education and training courses last for many weeks, requiring steady transportation arrangements. Job search activities involve frequent and unpredictable visits to employers as clients respond to employment opportunities. ET transportation funds allow for meeting these differing needs.

Transportation reimbursement is available in two ways. The client may either apply for reimbursement through the client's ET worker, or arrangements may be provided directly by the service vendor. Increasingly, ET is decentralizing its transportation program by providing funds to vendors, who have the ability to arrange vanpools and other cost-effective alternatives.

PREVIOUS TRAINING PROGRAMS

The Department, frequently in cooperation with the Division of Employment Security, has operated employment programs for a number of years. Federal regulations required the availability of these services. However, the programs included only a relatively small percentage of AFDC recipients, and the programs were not consistently an agency priority. In 1981, changes in federal regulations gave states considerably greater flexibility in designing employment programs, programs which the federal government would help pay for through Work Incentive Program (or WIN) demonstration funds.

The Work and Training Program (WTP), the state's first WIN demonstration project program, began in April 1982. WTP emphasized job search, both on a group and individual basis, prior to skills training, in order to quickly and inexpensively move off AFDC those recipients who were relatively job-ready and who could find jobs. Indeed, the program required all participants to spend five weeks in some type of job search. Only those recipients who presented evidence of having sought employment unsuccessfully could move on to the program's education and training components. Since many recipients had only limited education and little work experience, the jobs they could obtain without training were often jobs that paid relatively poorly and had an uncertain future. Recipients who objected to participating in WTP were subject to sanctions.

The Employment and Training (ET) Choices program became the state's WIN demonstration program in October, 1983. There are number of differences between ET and WTP. For example:

- o ET stresses education and training in preparation for long-term, self-sustaining employment;
- o ET recruits AFDC recipients for participation in program activities;
- o In order to attract committed participants, the ET program is designed to accommodate the varied needs of recipients; and
- o ET offers transportation, child care and health -- support services that are crucial to the program's ability to place individuals into jobs and help them stay employed.

The Department believes that ET's performance to date proves that a choice-based employment program for AFDC recipients can be successful.

FY87 REQUEST

	Projected FY86 Expenditures (in thousands of \$)	FY87 Request
1. <u>Division of Employment Security</u>	<u>\$6,820</u>	<u>\$7,080</u>
2. <u>Skills Training</u>	<u>\$5,975</u>	<u>\$7,370</u>
a. Job Training Partnership Act	3,600	4,000
b. Bay State Skills Corp.	625	1,000
c. Skills Training Contracts	1,500	1,750
d. Boston Works	50*	220
e. Commonwealth Service Corps	200*	400
3. <u>Supported Work</u>	<u>\$5,500</u>	<u>\$5,800</u>
4. <u>Adult Literacy</u>	<u>\$2,685</u>	<u>\$5,115</u>
a. Job Training Partnership Act	900	1,500
b. Literacy Contracts	1,500	2,250
c. Department of Education	200*	1,100
d. General Equivalency Degree	35	35
e. Boston Works	50*	230
5. <u>College Vouchers</u>	<u>\$600</u>	<u>\$1,000</u>
6. <u>Targeted Populations</u>	<u>\$1,110</u>	<u>\$2,610</u>
a. Displaced Homemakers	385	385
b. Youth Services	500	2,000
c. Women's Entrepreneur Program	100	100
d. Transitional Services	125	125
7. <u>Career Planning</u>	<u>\$1,375</u>	<u>\$1,000</u>
8. <u>Program Support</u>	<u>\$3,315</u>	<u>\$4,260</u>
a. Transportation	750	1,500
b. Personnel	2,303	2,500
c. Travel	12	10
d. Marketing	<u>250</u>	<u>250</u>
TOTAL	\$27,380	\$34,235**

* These are partial-year programs. The annualized level of FY86 projected spending is \$29 million. The FY87 request provides for \$5 million in expansion funds.

** Includes \$20.8 million in 4407-1000 and \$13.4 million in anticipated federal funds.

SUMMARY OF FY87 REQUEST

1. Division of Employment Security \$7,080,000

The FY87 request is for 5,900 placements. The amount shown would allow for payment of \$1,200 per placement, which is the FY86 payment rate.

2. Skills Training \$7,370,000

An array of skills training options, as described below, are available to ET participants:

- A. Job Training Partnership Act (JTPA) System \$4,000,000

In FY87, the ET contract would provide skills training in fields such as electronic technology, respiratory therapy and computer operation for 1,334 recipients and place 866 into jobs. Emphasis would be placed both on job quality, as measured by average wages, and on job placement.

- B. Bay State Skills Corporation (BSSC) \$1,000,000

The BSSC contract targets high skill/high wage occupations. The FY87 request would serve 333 individuals and place 217 into employment. As with the JTPA agreement, emphasis would be placed both on job quality, as measured by wages, and on job placement.

- C. Skills Training Contracts \$1,750,000

In FY87, the Department would fund innovative programs that are submitted through the RFP process. The amount shown would fund 648 training slots, which would result in 421 individuals placed into employment in FY87.

- D. Boston Works \$220,000

The Boston Works program is a proposal for expanded employment and training services for Boston residents. The program will be a collaborative effort funded through state, city, foundation and corporate contributions. The amount shown would be the state contribution for the skills training component of Boston Works. 96 recipients would receive vocational training and 62 placed into jobs.

- C. Commonwealth Service Corps \$400,000

Through an interagency agreement with the Executive Office of Communities and Development, the Department will fund increased ET participation in the Commonwealth Service Corps (CSC). The amount shown would be provided for 470 participants.

3. Supported Work \$5,800,000

In FY86, the supported work program expanded the geographic range of its services, offering supported work activities through vendors located in western Massachusetts. In FY87, the supported work program would maintain its FY86 service level, providing services to 3,000 individuals and placing 1,400 into jobs.

4. Adult Literacy \$5,115,000

The following education options are available through ET:

A. Job Training Partnership Act System (JTPA) \$1,500,000

The ET interagency agreement with JTPA includes funds for basic education activities in addition to skills training. The amount shown would fund 750 individuals in JTPA basic education courses, with 525 of these individuals entering skills training upon completion.

B. Literacy Contracts \$2,250,000

Through an Education and Training RFP, the Welfare Department directly funds educational courses such as Adult Basic Education, English as a Second Language, and General Equivalency Degree Programs. The amount shown would serve 2,250 individuals in FY87. Approximately 1,575 of these participants would enroll in skills training courses upon completion of basic education.

C. Department of Education (DOE) \$1,100,000

In FY87, ET will establish an interagency agreement with DOE that will link more closely the state's adult learning centers with ET training programs. The agreement will provide for a literacy and remedial skills initiative that will increase the educational skills of ET clients.

D. General Equivalency Degree (GED) Voucher \$35,000

The ET program offers a voucher to clients who are prepared to take the GED test. The voucher pays for all testing fees, which average \$20 per client, thereby removing a barrier for clients who want to complete their high school education. The amount shown would fund 1,750 GED vouchers.

E. Boston Works \$230,000

As described earlier, the Boston Works program is a collaborative employment and training proposal funded through state, city, foundation and corporate contributions. The amount shown would be the state contribution for the literacy component of Boston Works, serving 220 recipients in FY87.

5. College Vouchers \$1,000,000

In FY86, the college voucher program expanded to include all state funded institutions of higher education, thereby making college enrollment accessible to more ET clients. Each client may use the college voucher to enroll in a maximum of two college courses. Upon completion, clients may continue higher education through a federal Pell grant. The amount shown would allow an estimated 4,200 individuals to use ET vouchers, enrolling in 5,400 courses in FY87.

6. Targeted Populations \$2,610,000

In an effort to design service for specific AFDC populations, the ET program will implement several targeted initiatives in FY86. In FY87, these programs would continue to service client groups who need additional training and specialized services before entering employment. These programs are detailed below:

A. Displaced Homemakers \$385,000

The Bay State Skills Corporation's Displaced Homemaker program would serve 650 individuals and place 461 into education, training or employment in FY87.

B. Youth Initiative \$2,000,000

Approximately 1,800 youth clients would be served in initiatives developed with the Department of Education, the Department of Public Health and the Job Training Partnership Act.

C. Women's Entrepreneur Program \$100,000

The Women's Entrepreneur Program includes intensive training, one-on-one business mentor opportunities, and the provision of start-up capital for women who want to develop their own employment opportunities. ET will work closely with the Governor's office to develop the entrepreneur program.

D. Transitional Services \$125,000

Increased job retention rates are critical to the success of the ET program. A contract with Bay State Skills Corporation for transitional services will provide follow-up, counseling and support for ET graduates to insure that individuals remain permanently employed. The contract would serve 357 individuals in FY87.

7. Career Planning \$1,000,000

The amount shown would provide for 4,000 assessments in FY87 at the established rate of \$250 per assessment.

8. Program Support

\$4,260,000

Successful implementation and management of ET is contingent on a variety of program support services, as described below:

A. Transportation

\$1,500,000

ET participants are eligible for up to \$10 per day in reimbursement for transportation expenditures.

B. Personnel

\$2,500,000

The amount requested would fund 97 Full Time Equivalency positions. The ET account funds both central and field office staff.

C. Travel

\$10,000

The travel subsidiary pays expenses for travel to conferences, workshops and training sessions.

D. Marketing

\$250,000

The success of the Employment and Training program depends upon its positive reception by clients, Employment and Training field workers and the business community. The outreach efforts include expenditures for direct mailings in English and Spanish, public service announcements, brochures, job fairs and career days.

E. Other Support Services

ET Health Choices

(Funds requested in account 4407-1012)

Full-time employment does not guarantee economic independence for AFDC recipients. When clients move out of poverty and off of AFDC, they lose Medicaid benefits as well. In FY87 the Department proposes the establishment of a health care program to assist 2,250 ET graduates during the first year of employment. For a detailed description of the proposed health program, see the ET Health Choices narrative.

Voucher Day Care

(Funds requested in account 4400-1009)

In FY87 the average cost of day care will be \$2,800 per year, although the cost can be as high as \$5,000 per year. For the average ET participant or graduate, these costs create a formidable barrier to self-sufficiency. Thus, day care has become an integral part of ET. For a detailed discussion of the voucher day care program, see the voucher day care narrative.

VOUCHER DAY CARE (4400-1009)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures	\$5,075,058*	\$8,808,574	\$18,000,000	\$21,525,152
Caseload	2,323	3,435	5,258**	6,312**

The ET Choices program provides child care to ET registrants while they are participating in an ET component and to ET graduates during their first year of employment. After this first year, the long-term day care needs of many ET graduates are met through the Department of Social Services' contracted day care system.

Voucher day care is the primary support service for the Department's Employment and Training (ET) Choices program and is critical to its success. One of the most significant barriers to employment for AFDC recipients, and single parents in general, is the lack of affordable child care. Since AFDC families, by definition, include one or more children under the age of eighteen, child care must be available in order for the parent to work. However, child care is both expensive and difficult to find:

- o Child care costs range from \$2,000 to \$5,000 per child annually, depending upon the age of the child, geographic location, and the type of day care arrangement. Costs are particularly high for infants and toddlers, and for children with special needs.
- o The Child Care Resource Center, the largest child care information and referral agency in the Boston area, conducted a survey and found that almost 30% of parents currently not working weren't working because of an inability to find or pay for child care. 10% said they actually had to quit their jobs because of child care problems.
- o A Census Bureau survey of mothers who were not working found that 45% of single mothers, and 36% of all mothers whose family income was less than \$15,000, would work if affordable child care were available.

* Funding included \$3.9 million from the voucher day care state appropriation and an additional \$1.2 million from federal Work Incentive Demonstration funds for the ET program.

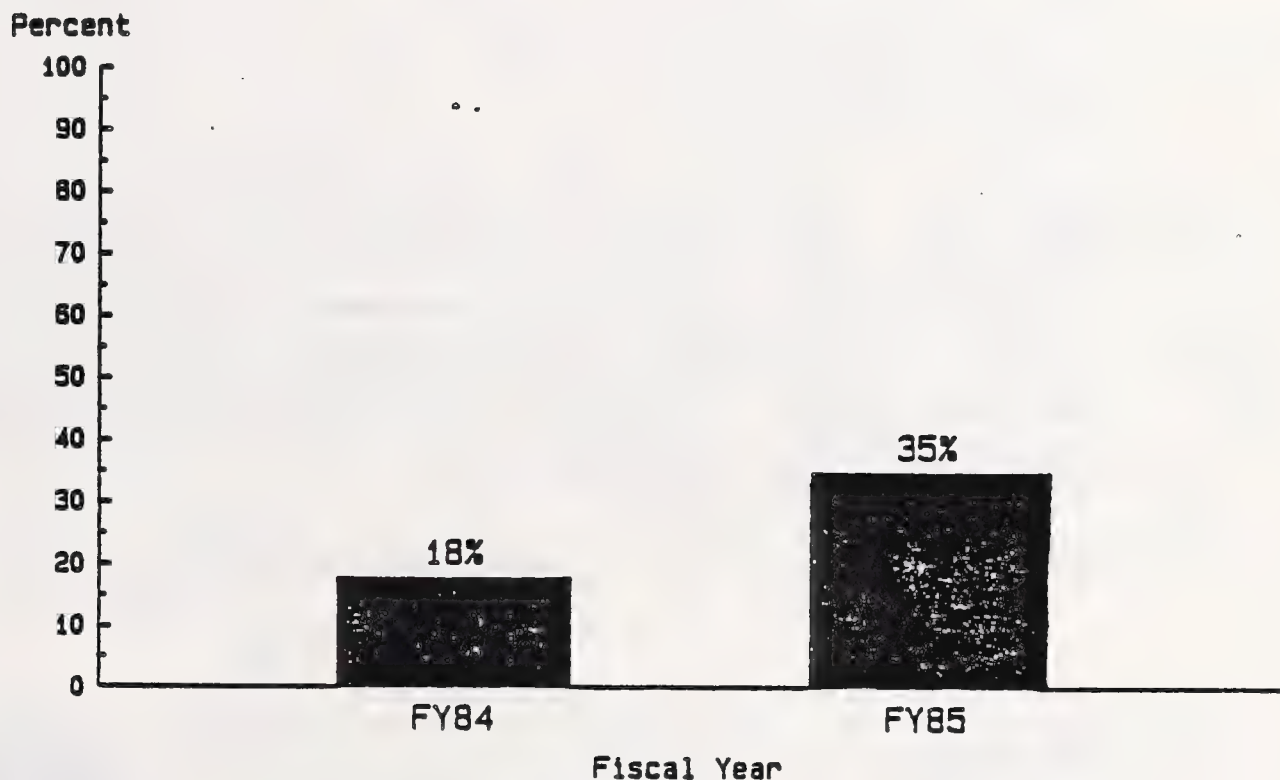
** FY86 and FY87 caseload and expenditure figures include children served in the Department's independent child care system.

The Department is committed to removing this barrier by providing child care to ET registrants while they are participating in an ET component and to ET graduates during their first year of employment.

Voucher day care has proven to be a critical participation incentive, enabling thousands of clients to volunteer for the ET program--including those who are officially exempt from participation under federal guidelines:

- o A significant and growing proportion of ET participants are women with children under the age of six. In FY84, the first year of the program, 18% of ET participants had at least one child under the age of six. In FY85, this percentage had nearly doubled--to 35%.

**ET PARTICIPANTS
With at least one child
under the age of six**



- o A recent analysis of voucher day care utilization revealed that five times as many women with children under the age of 6 use voucher day care as women whose children are age 6 or older.

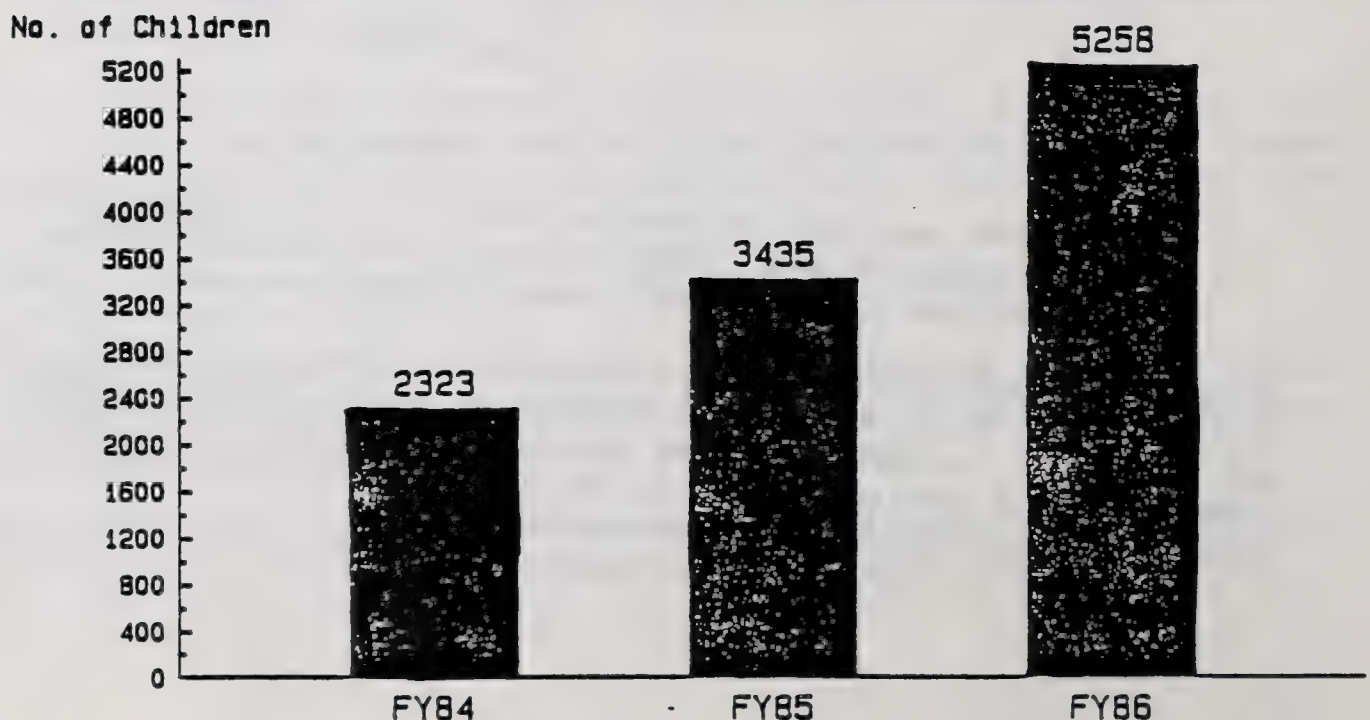
Because the Department provides this crucial support service, clients do not have to wait until their children enter school before seeking employment. Voucher day care makes it possible for them to become independent of public assistance much sooner than they might otherwise have -- benefitting clients and taxpayers alike.

PERFORMANCE 1983-1986

Massachusetts has long been recognized as a national leader in its commitment to child care. Since FY84, the present administration and the legislature have worked to ensure that quality, affordable child care is available to meet the needs of all working parents, but in particular the needs of low-income families. Significant accomplishments include:

- o Massachusetts was one of the first states in the country to appropriate state funds specifically for the purpose of providing child care to AFDC clients participating in an employment and training program. By the end of FY86, approximately \$32 million will have been spent to provide day care to ET participants and graduates through the voucher day care program.
- o Recognizing that quality, affordable child care is critical to a client's ability to remain self-sufficient, in FY85, the Department, with the support of the legislature, extended the eligibility of ET graduates for voucher day care from three months to one year after employment. In FY86, an estimated monthly average of 1,576 children of ET graduates will receive voucher day care at a cost of \$4.2 million.
- o Massachusetts is one of only 12 states which have increased their support of child care for low and middle-income families since 1981. The total number of state-funded day care slots for low and middle-income families (basic and supportive day care slots in the DSS contracted day care system, and the Department's voucher day care program) has increased by 26% between June, 1983 and June, 1986 -- from 18,639 to 23,450. The average number of children served each month in the voucher day care program has increased by 126% from FY84 to FY86 -- from 2,323 to 5,258.

VOUCHER DAY CARE Average Mo. Caseload FY84 - FY86



- o The administration, with support from the legislature, has made significant progress in improving the quality of child care by increasing the wages of child care workers, providing funds for 23 additional licensors at the Office for Children, and negotiating with insurance companies to obtain liability insurance coverage for family day care homes.

Increasing the supply of quality, affordable child care for low-income families has played an important role in the administration's efforts to extend economic opportunity to all. Voucher day care, because it is the primary support service for ET, has been especially important in helping AFDC clients to move out of poverty and become self-sufficient. The FY87 voucher day care request is designed to support the ET program in meeting its FY87 goals of 10,000 placements and 30,000 participants.

THE VOUCHER DAY CARE PROGRAM

A. Eligibility

All ET registrants are eligible to receive voucher day care while they are participating in one of the ET components, such as education and training, supported work, or job search and development.

In addition, the Department provides day care to the children of ET graduates during the first year of employment. Since the annual cost of child care can range from \$2,000 to \$5,000 per child, without a subsidy most ET graduates would have to pay at least one-third of their annual salary for child care expenses. The Congressional Budget Office has estimated that after meeting other major expenses such as rent or mortgage, groceries, and utilities, the average family cannot afford more than 10% of income for child care. In order to ensure that the high cost of child care is not a barrier to remaining employed, in FY85, the Department extended eligibility for voucher day care from 3 months to one year after employment for ET graduates.

ET participants and graduates are also eligible to receive child care through the Department of Social Services' (DSS) contracted day care system. The contracted day care system is the Commonwealth's primary means of delivering subsidized day care. DSS contracts with day care centers and family day care systems around the state to provide child care to low-income families. The Department believes that ET graduates benefit from the stable, long-term day care arrangements of the contracted system. DSS voucher management agencies encourage ET graduates in their first year of employment to place their names on waiting lists for an appropriate contracted slot and transfer them to these slots as they become available. The Department and DSS currently project that an average of 66 contracted slots per month will be available for voucher transfers in FY87.

The number of ET graduates approaching the end of their one year eligibility for voucher day care each month, however, is usually greater than 66. In FY86, the Department began to temporarily extend

the vouchers of ET graduates unable to transfer to a contracted slot before the end of 12 months in order to ensure continuity of care for their children. The Department intends extended vouchers to be used only until an appropriate contracted slot becomes available, and closely monitors the number of voucher transfers each month.

B. Service Delivery System

o Voucher Management

Through an interagency agreement, the Department of Social Services (DSS) manages the voucher day care program for the Department. DSS has both expertise in the delivery of child care services and strong ties to day care providers in the contracted day care system, resulting in significant benefits to the Department's clients.

DSS manages the program through a statewide network of 10 voucher management agencies (VMAs). The primary responsibility of VMAs is to help ET participants and graduates find child care by providing information and referral services. In addition, VMAs recruit new day care providers for the voucher system by working with communities to develop more day care resources and by providing training and technical assistance to providers. Some examples of these initiatives include:

- In Lowell, over 100 children of ET clients were on waiting lists for voucher day care at the beginning of this fiscal year. The majority of these children were school-age and required after-school care. Community Teamwork, Inc. (CTI), the VMA for the Lowell area, began working with community organizations such as the YMCA and YWCA, Boys' and Girls' Clubs, and the local schools to develop after-school programs. By October, the waiting list was reduced by more than half.
- The VMA in the New Bedford area, P.A.C.E., has been working with the local housing authority and EOCD to make use of EOCD supportive services funds to develop day care programs in local housing projects. To date, P.A.C.E. has succeeded in developing one family day care system and is working to develop others.

o Client Access

ET registrants must go through several steps before their children are placed in day care and they can begin participating in ET. The first step is appraisal and the development of an employment plan. During this process, ET workers assess the child care needs of clients, and fill out authorization and referral forms for those clients who will need voucher day care while they are participating in ET. Clients take these forms to their DSS voucher management agency or to VMA staff co-located in Welfare offices. Voucher counselors interview clients to

determine their specific day care needs and preferences, provide information and referral services, and issue vouchers to clients once they choose a provider.

Consistent with the sliding fee scale established by DSS for the contracted day care system, clients participating in the voucher day care program must pay a small fee. These fees vary with a client's ability to pay and are paid directly to the provider to contribute towards the cost of voucher day care services. The fee varies according to the client's income, the type of day care arrangement, family size, and the number of children receiving care. The average AFDC client participating in ET pays \$3.85 per week. The average client placed into a job through ET pays \$12.55 per week.

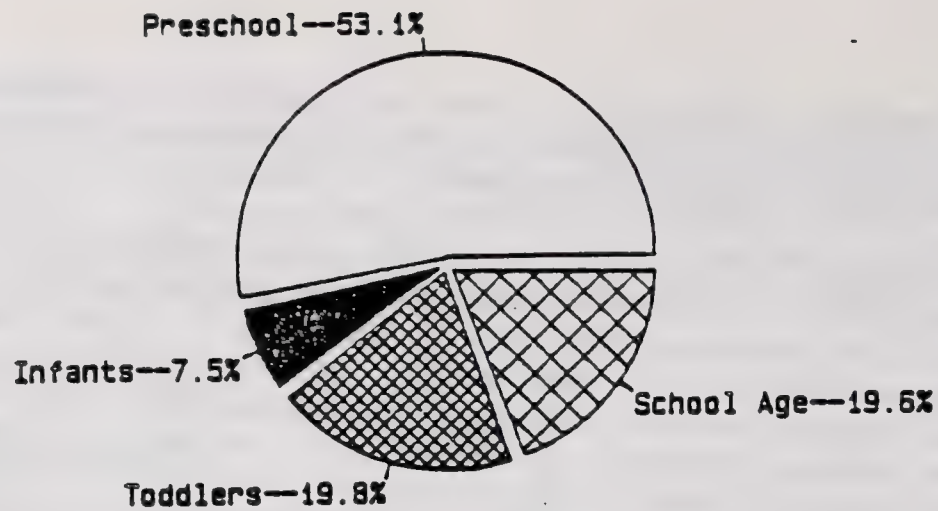
C. The Advantages of Voucher Day Care

While the DSS contracted day care system offers the advantage of permanence to working clients with stable day care needs, the voucher system offers ET participants more flexibility. In particular, independent family day care homes registered with the Office for Children are eligible to participate in the voucher day care program. In contrast, DSS contracts only with day care centers and family day care systems. The voucher day care system offers ET clients a much wider range of providers to choose from. Flexibility is also important to clients who work non-traditional hours or who may have limited day care needs because their training or education component meets only several hours a day or a couple of days per week. Such needs can be met more easily through the voucher system. Finally, the voucher system is more able to respond to the immediate needs of ET participants. When an individual is scheduled to begin a training program and has chosen a provider, a voucher can be issued immediately, preventing delays in participation. Under the contracted day care system, the consumer has to wait for a slot in the appropriate geographic region and program type to become available.

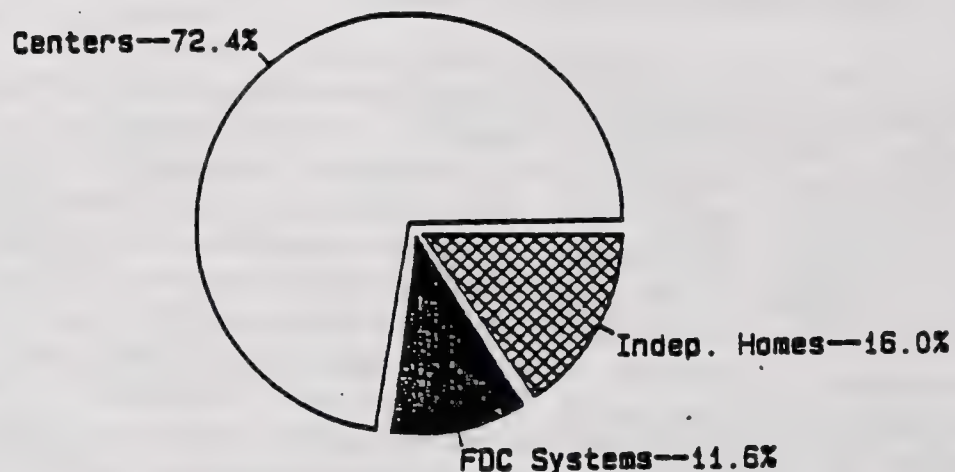
DEMOGRAPHICS

A. Ages of Children

In April, 1985, over 80% of the children receiving voucher day care were infants, toddlers and pre-school age; almost 20% were school-age. The percentage of children receiving voucher day care who are under the age of six has increased steadily, from 75% in November, 1983 to 80% in April 1985 -- one indication that the Department has been successful in encouraging voluntary participation in ET.



Ages of Children



Type of Care

B. Types of Child Care

The voucher system delivers care in three settings: centers, family day care systems, and independent family day care homes. Day care centers are child care facilities located outside of the home that provide full or part-time care in a group setting. Family day care is provided in private homes that serve no more than six children. Family day care systems are composed of a group of family day care homes that have a formal arrangement to receive training and technical assistance through the system and, unlike independent homes, are eligible to bid for DSS contracts. The state's Office for Children monitors the quality of all of these programs through licensing and registration.

In November 1985, the percentage of children in the voucher day care program receiving care in independent family day care homes was 16.0%, in family day care systems 11.6%, and in centers 72.4%. The proportion of voucher children in family day care systems and day care centers has increased steadily since FY84 -- from 79% in November, 1983 to 84% in November, 1985, facilitating voucher transfers to contracted slots.

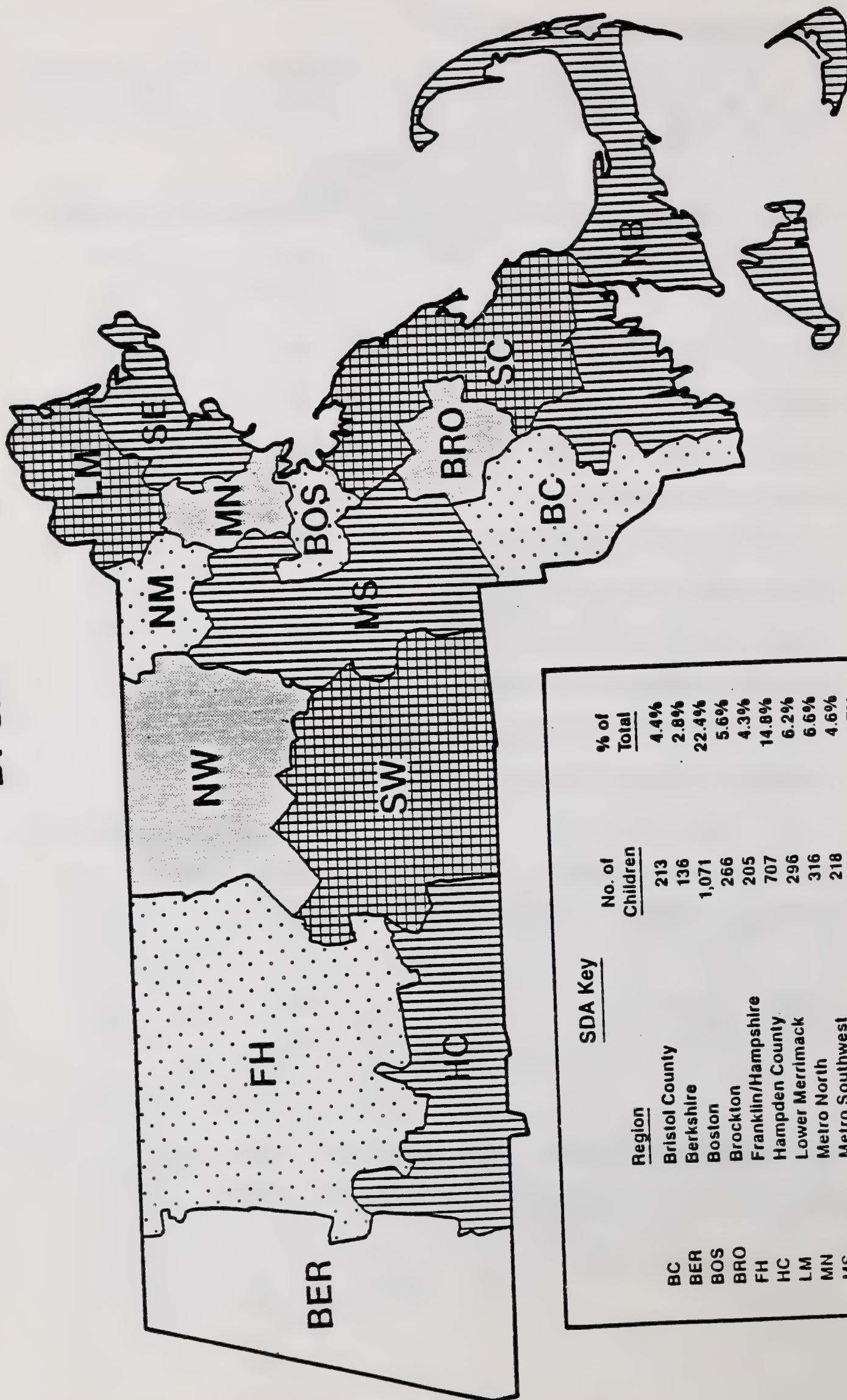
C. Regional Distribution of Caseload

Each VMA is responsible for covering a geographic area corresponding to one or more of the Job Training Partnership Act (JTPA) service delivery areas (SDAs). The voucher day care caseload by SDA in November, 1985 was:

<u>SDA</u>	<u>Number of Children</u>	<u>% of Caseload</u>
Berkshire (Pittsfield)	136	2.8
Boston	1,071	22.4
Bristol (Fall River)	213	4.4
Brockton	266	5.6
Franklin/Hampshire (Greenfield)	205	4.3
Hampden (Springfield)	707	14.8
Lower Merrimack (Lawrence)	296	6.2
Metro North (Cambridge)	316	6.6
Metro South/West (Norwood)	218	4.6
New Bedford/Cape Cod & Islands	223	4.7
Northern Middlesex (Lowell)	69	1.4
Northern Worcester (Gardner)	226	4.7
South Coastal (Quincy)	207	4.3
Southern Essex (Salem)	170	3.6
Southern Worcester (Worcester)	<u>458</u>	<u>9.6</u>
STATEWIDE TOTAL	4,781	100.0%

Almost one-quarter of the voucher day care caseload is in Boston. Another 25% is in the Springfield and Worcester areas.

FY86 VOUCHER DAY CARE CASELOAD BY SDA



SDA Key

Region	No. of Children	% of Total
BC	213	4.4%
BER	136	2.8%
BOS	1,071	22.4%
BRO	266	5.6%
FH	205	4.3%
HC	707	14.8%
LM	296	6.2%
MN	316	6.6%
MS	218	4.6%
NB	223	4.7%
NM	69	1.4%
NW	226	4.7%
SC	207	4.3%
SE	170	3.6%
SW	458	9.6%
TOTAL	4,781	100.0%

FY87 BUDGET REQUEST

The Department is requesting \$21,525,152 in FY87 for voucher day care. This funding will provide child care to an average of 6,312 children each month, supporting the Department's FY87 ET goals of 30,000 participants and 10,000 placements. This request funds services for new ET participants and placements in FY87, as well as the annualized costs of FY86 ET participants and placements who have continuing needs for service.

	<u>Funding</u>	<u>Average Monthly Caseload</u>
1. ET Participants (FY87)	\$5,031,936	1,872
2. ET Participants (FY86)	5,894,784	2,193
3. ET Placements (FY87)	2,306,304	858
4. ET Placements (FY86)	1,951,488	726
5. Extended Vouchers	599,424	223
6. Independent Child Care	<u>1,056,771</u>	<u>440</u>
 Direct Service Subtotal	 \$16,840,707	 6,312
 7. Voucher Management Costs	 \$2,835,087	
8. Day Care Transportation	1,166,400	
9. Provider Rate Increase	<u>682,958</u>	
(4% COLA)		
 TOTAL FY87 REQUEST	 \$21,525,152	

o Direct Service Costs

\$16,840,707

Direct service costs are the costs associated with providing voucher day care and independent child care services directly to clients. Provider wages, geographic location, ages of children, and the type of day care arrangement are all factors that influence a voucher provider's daily rate, which is negotiated by DSS following guidelines on maximum daily rates set by the Rate Setting Commission. In FY87, the Department projects the annual direct service cost per child to be \$2,796 in the voucher day care system.

The FY87 request includes the costs of providing voucher day care services to an average of 5,872 children of ET participants and placements per month, as well as the costs of the ET independent child care system.

The ET independent child care system is intended to serve as an alternative to the voucher day care system when vouchers are temporarily unable to meet the child care needs and preferences of clients. Providers participating in the independent system are paid \$1.00 per hour per child. In FY87, the Department projects that an average of 440 children per month will be served in this system.

o Voucher Management

\$2,835,087

Management costs are the administrative costs of running the voucher program. In FY87, Welfare will pay for the costs of DSS central office staff administering the voucher day care program, as well as the costs of 10 voucher management agencies (VMAs). Costs include staff salaries, space and equipment rental, supplies and other administrative items. In FY87, administrative costs are projected to total:

DSS Central Office Unit	\$ 380,000
Voucher Management Agencies	<u>2,455,087</u>
	\$2,835,087

o Day Care Transportation

\$1,166,400

The Department of Social Services, voucher management agencies, and ET workers have all identified transportation as a major barrier in accessing day care. In FY86, the Department will pay a transportation allowance to ET participants whose children are in day care. Participants will be reimbursed only for their actual, documented costs of day care transportation up to a maximum of \$10 per day. This will help ensure that ET participants have enough money to get themselves to school or training, and their children to day care. In FY87, the Department requests funds to continue to provide this support service at a projected cost of \$1.2 million.

o Provider Rate Increases

\$682,958

In FY86, the Rate Setting Commission approved a 4% cost-of-living adjustment in the maximum daily rates for day care providers. Providers in the DSS contracted system received an additional 7% increase as part of the provider parity initiative for human service providers. In FY87, the Department requests funds for a potential 4% cost-of-living adjustment in maximum daily rates which may be authorized by the Rate Setting Commission, at an estimated cost of \$682,958.

EMPLOYMENT AND TRAINING FOR GENERAL RELIEF RECIPIENTS (4407-1010)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures	--	\$605,075	\$1,876,000	\$2,392,000
Job Placements	--	312	900	1,075

In FY85, the Department made major strides in extending opportunity to all by expanding ET Choices to include employment and training services for General Relief clients. In FY86, the Department further expanded the options available to GR recipients by offering the GR Choices program.

GR CHOICES

The General Relief program aids approximately 25,000 of the neediest men and women in the Commonwealth. Approximately 60%, or 15,000 individuals, are physically or mentally disabled; approximately 700 are homeless. While cash grants for some recipients have risen 35% since FY82, GR benefits are still currently only 55% of the poverty line. These factors, combined with limited educational opportunities and support services, have made it extremely difficult for GR clients to move out of poverty.

In FY86, the Department implemented the GR Choices program to assist clients in obtaining meaningful employment, economic independence and a way out of poverty. GR Choices offers the following services to clients:

- o Direct placement into GR ET for clients who are ready to enter training, education, and job placement programs.
- o Appraisal by the Massachusetts Rehabilitation Commission (MRC) for physically or mentally incapacitated clients. Depending on their background, interests, and rehabilitative barriers, clients will receive the following services:
 - Placement into MRC vocational rehabilitation programs, with eventual job placement; or
 - Placement into GR ET programs, with future placement into unsubsidized employment.
- o Assistance with SSI applications for severely disabled clients. Conversion to SSI will provide these recipients with benefits that are 80% higher than GR benefits and that include automatic Medicaid eligibility.

Through strong case management and support services, GR Choices will place 1,000 individuals into employment and enroll 500 recipients into

SSI in FY87. The components of the GR Choices program are summarized below.

<u>Component</u>	<u>FY87 Placement Goal</u>
GR Employment and Training	900*
MRC Placements	100
MRC Vocational Rehabilitation	125
SSI Conversions	500

*Does not include placements from supported work programs for the mentally disabled.

The narrative that follows describes the General Relief Employment and Training program. See the General Relief narrative for a more detailed discussion of the GR Choices program and the clients it serves.

GENERAL RELIEF EMPLOYMENT AND TRAINING

A major component of GR Choices is the General Relief Employment and Training program (GR ET). GR ET began operating in December 1984 as the Department expanded the Employment and Training program for AFDC recipients to include services for General Relief clients. The GR ET program was established to reflect the Department's goal of offering realistic economic opportunities to all welfare clients. The focus of GR ET is to prepare clients for job placement and economic self-sufficiency.

Between December 10, 1984, when the program began, and June 30, 1985, GR ET placed 312 clients into employment. In the first six months of FY86, the program has placed an additional 515 clients into jobs, or 57% of the FY86 placement goal. In FY87, the placement goal is 900 new job placements.

GR ET is a fully state-funded program that is modeled after ET Choices. The program options available for GR ET participants are:

- o Career planning;
- o Education and training;
- o Supported work; and
- o Job placement.

Through the provision of these services, GR ET offers clients the prospect of economic self-sufficiency and the opportunity to move out of poverty.

Participation in GR ET is completely voluntary, although the following GR client groups are targeted for services:

- o Families;
- o Individuals age 45 and over;
- o Ex-offenders;
- o Halfway house residents; and
- o Physically or mentally incapacitated individuals who are appraised and referred by MRC.

GR ET PROGRAM OPTIONS

GR ET offers the same program options as are available in ET Choices, so that clients may choose the service most appropriate for their employment goal. The GR ET components are:

A. Career Planning

Career planning is the first component chosen by many GR ET participants. Career planning offers skills testing and evaluation for clients who need assistance in establishing a specific training plan. Once an assessment has been completed, the client is prepared to enter one of the other ET components.

Career planning is particularly important for GR clients, many of whom have been without meaningful employment for some time, and may need specialized services to prepare for a job.

In FY86, ET implemented a career planning model, through contracts with the Job Training Partnership Act system (JTPA) and private vendors, which standardized career planning services and established performance-based payments. This service delivery model will be continued in FY87.

B. Education and Training

The education and training component provides the largest array of services available to GR ET participants. Similar to ET Choices, courses include skills training in fields such as electronic technology and machine trades. Educational opportunities range from Adult Basic Education and General Educational Development to college courses.

C. Supported Work

The supported work component is designed for individuals who have little recent work experience and a sporadic employment history. GR ET contracts directly with supported work vendors, who place participants directly into worksites, where they gradually move into.

full-time employment. The supported work program stresses graduated responsibilities, peer support and close supervision, so that the transition to self-sufficiency is successful.

D. Job Placement

Two job placement services are available for clients who are prepared to enter employment:

- o Division of Employment Security

The GR ET program contracts directly with the Division of Employment Security (DES) for job search and placement services. The DES contract is performance-based, and includes specific performance measures for job placements, retention, average wage and health insurance. Between December 10, 1984 and January 1, 1986, 871 GR ET participants obtained employment through DES.

- o Comprehensive Offender Employment Resource System (COERS)

COERS provides job development and placement services for ex-offenders who are receiving General Relief. A performance-based interagency agreement with the COERS administrative agency, the Executive Office of Economic Affairs, allows for this collaborative effort. The COERS performance measures are similar to those developed for DES, including job placements, retention rates and starting wages. Between January 1, 1985 and October 1, 1986, COERS placed 171 ex-offenders into employment at an average full-time wage of \$4.90.

E. Individual Purchase of Service

The development of the Individual Purchase of Service system (IPS), which allows for specialized services, reflects the unique quality of GR ET.

GR ET clients may enroll in programs funded by ET Choices, or in any course that offers free enrollment to welfare clients. However, before the development of IPS, private training courses that offered programs of interest to GR clients were unavailable to them. The IPS was developed for the purchase of course tuition and supplies so that private vendors could enroll GR ET clients. Thus, the IPS allows clients to enroll in a variety of programs that were not available before.

The IPS is also used to purchase special licenses, books or supplies that lead directly to job placement. This is a particularly cost-effective use of the IPS, since a small investment can lead to full-time employment and lasting economic self-sufficiency for clients.

The IPS is initiated in the local welfare office. The ET worker, who works closely with GR ET participants, submits a request to the ET central office where it is reviewed carefully by ET staff. If the

request is approved, a voucher is issued, which authorizes the service and triggers payment for the vendor.

GR ET PERFORMANCE IN THE FIRST YEAR

In the first year of operation -- between December 10, 1984 and January 1, 1986 -- the GR ET program has achieved significant results:

- o enrolled 3,901 participants
- o achieved 827 job placements, which is 10% above the first year goal
- o achieved an average full-time wage of \$5.20 per hour

The FY87 request will allow for the continuation of the program's successful performance.

FY87 REQUEST

	<u>Estimated FY86 Expenditures</u>	<u>FY87 Request</u>
1. Career Planning	\$ 116,000	\$ 116,000
2. Education and Training	\$ 300,000	\$ 300,000
3. Supported Work	\$ 100,000	\$ 200,000
4. Division of Employment Security	\$ 520,000	\$ 520,000
5. Comprehensive Offender Employment Resource System	\$ 300,000	\$ 300,000
6. Supported Worked for Mentally Disabled	\$ 540,000	\$ 956,000
TOTAL REQUEST	\$1,876,000	\$2,392,000

1. Career Planning \$116,00

In FY86, the ET program implemented a career planning model, which established uniform testing and evaluation throughout the state at a cost of \$250 per completed assessment. The 15 JTPA service delivery areas provide career planning, based on the program model, through a performance-based interagency agreement. The amount shown would provide 464 assessments in FY87 at the established rate of \$250 per assessment.

2. Education and Training \$300,000

The Education and Training component includes skills training courses in fields such as electronic technology and machine trades. Educational opportunities range from Adult Basic Education to General Educational Development. Individually purchased services are also included under this education and training request. Approximately 270 clients would be served in FY87 at an average cost of \$1,100 per person.

3. Supported Work \$200,000

Supported Work is designed for individuals with no recent work experience and a sporadic employment history. Participants are placed into worksites through ET contracts with supported work vendors. The program stresses graduated responsibilities, peer support and close supervision to ensure a successful transition to self-sufficiency. In FY87, the Department is requesting funding to serve approximately 60 individuals and place 40 into jobs.

4. Division of Employment Security

\$520,000

In FY85, DES placed 183 GR clients into jobs. The FY86 interagency agreement increased this placement capacity to 450 job placements. At the same time, the contract emphasizes job quality, as measured by the average hourly wage, and includes a \$100 per placement bonus when the average wage is above \$5.10 per hour.

The FY87 request includes funds for 430 placements. The amount shown would allow for payment of \$1,000 per placement, plus \$100 for a wage bonus. An additional \$100 per placement is included for a transition payment for clients who are entering employment.

5. Comprehensive Offender Employment Resource System

\$300,000

COERS placed 171 ex-offenders into employment, between January 1, 1985 and October 1, 1986, at an average full-time wage of \$4.90 per hour. The amount shown would provide for 250 placements in FY87, at the same cost per placement requested for DES.

6. Supported Work for Mentally Disabled

\$956,000

The GR ET account includes a specialized supported work program for mentally ill individuals. In FY86, two supported work vendors will provide services to approximately 180 individuals, and place 117 into employment. The clients served are recruited with assistance from the Department of Mental Health, and may be AFDC, GR, SSI or SSDI recipients. In FY87, in response to an RFP, this specialized program would expand to western Massachusetts, thus offering emotionally disturbed clients who live in the Springfield and Worcester areas an opportunity to participate. Vendors would provide services to approximately 350 clients, with a goal of 175 of these individuals entering employment. These placement figures are not included in the total GR ET placement goal.

PRESERVING OPPORTUNITY FOR ALL:

SPECIAL REPORT ON ASSISTANCE TO THE WORKING POOR

There were approximately 160,000 poor families in Massachusetts in 1983 (the latest year for which data is available). Over half of these families had one or more earners. These families are the working poor--families who are trying to remain self-sufficient, but whose lives are a constant struggle to make ends meet and to provide for their children. Many of these families need help as they make the transition from poverty to complete self-sufficiency.

The Reagan administration has made it more difficult to help these families by reducing its support of programs for low-income families and individuals. Since FY84, the legislature, the Dukakis administration, and the human services community have joined forces to fill in some of the gaps created by the federal government, by funding a number of crucial programs and support services for working poor families.

THE EFFECTS OF FEDERAL BUDGET CUTS ON WORKING POOR FAMILIES

...

Since 1981, federal budget cuts in anti-poverty programs have had a devastating impact on low and moderate-income families in the U.S. A Congressional Budget Office (CBO) analysis showed that federal programs for poor people were cut by \$57 billion during the period from FFY82 to FFY85. Although programs serving low-income individuals and families constitute less than 10% of the federal budget, they were the targets of nearly one-third of all cuts in non-defense programs made during the first Reagan administration. Some programs were completely eliminated, and restrictive eligibility requirements were imposed in others. Virtually no program was spared.

One of the groups most adversely affected by these cuts has been the working poor. In particular, changes in the Aid to Families with Dependent Children (AFDC) program which were mandated by the federal Omnibus Budget Reconciliation Act of 1981 (OBRA) have made it virtually impossible for families with earnings to qualify for this type of assistance. More than 25,000 families were eliminated from the Commonwealth's AFDC program in the first year after OBRA.

Before OBRA, an AFDC recipient who became employed was able to disregard "thirty and a third" of her earned income (that is, the first \$30 and a third of the remainder) from her grant calculation, and thus in many cases continue to receive some transitional measure of support until she became fully self-sufficient. OBRA limited the earned income disregard to the first four months after employment. In addition, OBRA restricted AFDC eligibility to families whose gross income was below 150% of the standard of need. Before OBRA, families were eligible for AFDC as long as their net income after deductions was below the payment standard. In effect, OBRA removed many of the incentives for AFDC recipients to seek employment and removed the cushion of support previously available to newly employed recipients as they moved towards financial independence.

The U.S. General Accounting Office (GAO) evaluated the effect of these changes upon AFDC families and found that:

- o Nationally, approximately 500,000 low-income working families became ineligible for AFDC and their benefits were terminated. Because these families also lost automatic entitlement to Medicaid, an estimated 700,000 children were no longer covered by any form of health care insurance.
- o Of a sample of families who had lost their AFDC benefits drawn from five cities in different parts of the country, more than half had run out of food at least once and had no money to buy more, and more than one-fourth had a utility shut-off due to inability to pay a bill.
- o Another 300,000 working families retained their eligibility for AFDC, but their benefits were sharply reduced by an average of \$150 to \$200 per month.

In Massachusetts, the effects of OBRA on the AFDC caseload have been no less dramatic:

- o In the first year after OBRA became effective, the AFDC caseload decreased by approximately 25,500 cases, from 120,548 to 95,051 -- a decline of 21% and the largest one-year decline in the history of the program. Approximately 16,400 cases with earnings, or over half of all earnings cases, were closed.
- o Prior to OBRA, almost 20% of the caseload had some earnings. In December 1985 only 8.8% did.

The GAO study and others like it, point out a sobering fact: many of the effects of the federal budget cuts in programs for the poor fell upon the same low-income working families. That is, not only did these families have their AFDC grants terminated or reduced, but many also became ineligible for Medicaid, received reduced Food Stamp benefits, and faced rent increases if they lived in subsidized housing. Although any one of these circumstances would cause hardship for these families, the cumulative impact of the federal budget cuts was severe.

FILLING IN THE GAPS: 1983-1986

Since FY84, the legislature, the Dukakis administration, and the human services community have joined forces to fill in some of the gaps created by the federal budget cuts. The ET program has enabled over 23,000 AFDC families to achieve self-sufficiency by providing them with the opportunity and support to overcome barriers to employment. In the AFDC program, the standard of need has been increased by 5% each year in FY83, FY84, and FY85 in order to extend eligibility for AFDC to some of the most needy working poor families. In addition, Supplemental Benefits were provided to an average of over 600 families per month in FY85. Supplemental Benefits protect clients who have lost a job and, because of

a federally-mandated retrospective budget system, would otherwise face a drastic reduction in their monthly income for two months until their grant was adjusted upward to reflect the loss of employment.

Other measures that the Commonwealth has taken since FY83 to help the working poor in the areas of health and nutrition, housing and energy, and support services for working parents, are described below.

A. Health and Nutrition

o Medicaid Income Standard Increases

Medicaid is the state and federally-funded, state-administered health insurance program for low-income families. Without Medicaid coverage, many of these families would forego necessary services or would exhaust limited cash resources in a medical emergency. All persons who receive cash assistance (AFDC or SSI) are automatically, or categorically, entitled to Medicaid coverage. Other families and individuals who are not eligible to receive cash assistance may still qualify to receive Medicaid if their income and resources are insufficient to meet their medical needs. Approximately one-half of these Medicaid-only households consist of families and individuals whose income meets Medicaid eligibility standards (\$5,964 for a family of three). The other half qualify because they incur major medical expenses which reduce their income below the Medicaid eligibility standard. Thus, Medicaid is a form of catastrophic health coverage for many low and moderate income families.

Federal budget cuts in the Medicaid program forced many states to eliminate Medicaid coverage for individuals and families who were not receiving cash assistance, or to eliminate coverage for certain services. In contrast, Massachusetts has increased the Medicaid income eligibility standards for individuals by 32% and for families by 14% between FY83 and FY86 -- allowing 3,300 more low-income families and individuals to receive necessary medical services.

o Food Stamps

The Food Stamp program is a federally-funded, state-administered program intended to help low-income households receive basic levels of nutrition. To qualify for Food Stamps, a family must meet several financial eligibility requirements. There is a gross income ceiling equal to 130% of the poverty line, or \$11,004 for a family of three. There are no substantial categorical requirements, thus both households receiving other forms of public assistance such as AFDC, General Relief, or SSI, and non-public assistance households can participate.

Funding for the Food Stamp program was also substantially reduced by OBRA. Nearly one million Food Stamp recipients lost their eligibility for the program due to changes in income eligibility standards, and virtually all other recipients had their benefits

reduced. Two-thirds of the cuts fell upon families whose income was below the poverty line.

Nevertheless, the Food Stamp program is still one of the only assistance programs many low-income working families qualify for. In order to ensure that these families are aware of their potential eligibility for the program, the Commonwealth has funded a Food Stamp outreach campaign. Minority communities and the elderly have been targeted in the campaign because they are more likely to suffer from malnutrition.

o Combatting Infant Mortality and Malnutrition

Perhaps no other state in the country has done as much as Massachusetts has in the past several years to combat the tragedy of infant mortality and malnutrition among low-income families. In 1982, the infant mortality rate in Massachusetts rose for the first time in nine years -- from 9.6 deaths per 1,000 live births in 1981 to 10.1 in 1982. The increase was even more dramatic in the city of Boston: from 11.9 per thousand in 1981 to 15.8 in 1982. Not surprisingly, these sudden increases in the infant mortality rate coincided with Reagan administration cuts in health and nutrition programs. In addition, the Department of Public Health released the results of a statewide survey in late 1983 which found that between 10,000 and 17,500 children in Massachusetts were stunted in their growth, due largely to chronic malnutrition. Nearly one of every five low-income children surveyed was either stunted, abnormally underweight, or anemic.

Since FY84, the Commonwealth has made a concerted effort to address the primary cause of infant mortality -- low birthweight due to poor prenatal care and nutrition. Improved health and nutrition services for pregnant women and young children helped push the infant mortality rate down to 8.9 deaths per thousand in 1983 -- the lowest in the state's history:

- Making women eligible for AFDC benefits during their first and second trimesters of pregnancy (a benefit removed by the Reagan administration in 1981 and extended under full state cost in 1984). In FY85, an average of 1,600 AFDC cases per month were pregnant women.
- Becoming the first state in the nation to supplement the federal Women, Infants, and Children (WIC) nutrition program with \$6 million in state funds, more than doubling the number of families served from 30,000 in 1982 to 63,000 in 1985. The WIC program is widely regarded as one of the most successful federal programs for low-income families, and has been linked in numerous studies to reductions in the incidence of low birthweight babies. Through WIC, poor pregnant women and young children receive nutrition counseling and food vouchers for selected nutritious foods.

In FY85, the legislature also funded a special project to increase utilization of WIC by Southeast Asian refugees.

- Appropriating \$6 million in FY86 for Project Healthy Start, a demonstration project to deliver pregnancy-related medical services to uninsured low-income women in the Commonwealth. A special state Task Force on Low Birthweight and Infant Mortality estimated that approximately 6,000 to 6,500 pregnant women each year are neither eligible for Medicaid nor covered by private health insurance for pregnancy-related medical services such as prenatal care, obstetric and gynecological services, delivery, and post-partum care. Project Healthy Start, managed by the Department of Public Health, will serve approximately 3,500 pregnant women and adolescents in FY86 whose income does not qualify them for Medicaid coverage, but is less than the WIC eligibility standard (185% of the poverty line, or \$16,373 for a family of 3).
- Creating 23 Maternal and Infant Care Projects which provide prenatal and post-partum care to 4,000 low-income women and teenagers.
- Establishing Failure-to-Thrive programs at 8 sites across the state which provide diagnosis, treatment and referral services to 500 children with severe growth retardation.

B. Housing and Energy

o Affordable Housing

The federal government has cut housing assistance funds by 60% between 1981 and 1985, from \$32 billion to \$10 billion -- the largest reduction in any single domestic program. Rents have been raised for all four million low-income families living in public or subsidized housing. Prior to the budget cuts, families living in public or subsidized housing paid no more than 25% of their income for rent. Since 1981, rents have been raised every year and will reach 30% of income this year. In addition to rent increases, federal support for the construction and rehabilitation of low-income housing units has been cut by two-thirds, and the federal Department of Housing and Urban Development (HUD) has opposed building any new publicly-assisted housing units at all. Continued construction and rehabilitation of low-income housing is crucial, however, in offsetting the losses in low-income housing stock that occur each year due to condominium conversion, rent increases, abandonment, and decay.

The shortage of affordable housing for low and moderate-income families has been particularly acute in Massachusetts because of a high level of condominium conversions due to a healthy economy, and a tight private housing market in the Boston area, where average rents have increased by more than 50% in the past five

years, and occupancy rates often exceed 98%. At \$530, the median rent in Boston is the highest in the country, and is almost \$100 above the maximum AFDC grant of \$432 for a family of three.

Condominium conversions numbered 7,000 between 1980 and 1983, and sold at a median price of \$62,000 -- well out of reach for working poor families.

In the past few years, Massachusetts has acted to alleviate the low-income housing shortage by:

- Passing tough legislation restricting condominium conversions (Chapter 257 of the Acts of 1983). Under the law, landlords must: give one year notice to all tenants, and two years notice to low and moderate-income, elderly, and handicapped tenants; give an additional two year extension to low and moderate-income, elderly and handicapped tenants if the landlord cannot locate comparable housing within the notification period; pay moving expenses of \$750 to most tenants and \$1,000 to low and moderate-income, elderly or handicapped tenants; and restrict all rent increases during the notification period to the increase in the CPI or 10%, whichever is lower.
- Providing more than 14,000 additional low and moderate-income housing units through the Comprehensive Housing Act of 1983 (\$196.6 million for the development of 2,600 new or rehabilitated low-income housing units for the elderly, families, and the handicapped); the SHARP interest subsidy program (3,380 units); moderate income mortgages (4,800 units); and the Chapter 707 Rental Assistance program (3,500 units). The 707 program, operated through local housing authorities or non-profit organizations, helps families and individuals locate and pay for affordable housing. Families receiving housing through the program pay no more than 25% of their income for rent, and the local housing authority or non-profit organization contracts with the landlord to pay the difference. The 3,500 Chapter 707 Rental Assistance certificates issued between FY83 and FY85 represent a marked improvement over the two years prior to 1983 when no new 707s were issued.

In addition to the above measures, the Executive Office of Communities and Development (EOCD) intends to provide another 18,200 units in 1985 and 1986, including 3,500 units authorized by the \$344.4M housing bond bill recently passed by the legislature, bringing the number of new low and moderate-income housing units to a 4 year total of nearly 33,000.

o Emergency Assistance

Emergency Assistance (EA) includes services offered by the Department of Public Welfare to respond to particular emergencies, ranging from eviction to natural disasters, such as fires and floods, which threaten families with the prospect of homelessness or cause serious hardship. The most common services provided are:

- Advance rent and security deposits;
- Emergency shelter;
- Payment of rental, gas, electric and oil arrearages; and
- Repair and replacement of major appliances.

In 1983, Chapter 450 of the Acts of 1983 (An Act to Prevent Homelessness) reformed the Emergency Assistance program to make it more responsive to the needs of low-income families. In addition to extending eligibility for EA to families who were not receiving public assistance, but whose gross income fell below 185% of the state's standard of need, Ch. 450:

- eliminated restrictive caps on the amount of payments for utility and rent arrearages, advance rent and security deposits, and hotel and motel stays; and
- authorized Emergency Assistance for the prevention of homelessness during certain critical situations such as residential overcrowding or violence against a family member.

EA expenditures have increased from \$7.5 million in FY83 to an estimated \$34 million in FY86 as a result of these reforms. By providing assistance during an emergency, the Commonwealth has helped prevent significant financial hardship and homelessness for many low-income families.

o Fuel and Energy Assistance

Another major expense for poor families is the high cost of heat and other utilities. In addition to payment of gas, electric, and oil arrearages through the Emergency Assistance program, Massachusetts operates several fuel and energy assistance programs for low and moderate income families:

- The Low-Income Home Energy Assistance Program (LIHEAP) provides primary heat assistance to approximately 165,000 households in Massachusetts. LIHEAP is state-administered and jointly funded by the Commonwealth and the federal Department of Health and Human Services. Almost \$100 million is available for LIHEAP in FY86, including \$17 million in state-appropriated funds.

- EOCDC administers a number of Weatherization Assistance Programs totalling approximately \$20 million and funded by four separate sources: the Departments of Energy, Health and Human Services, and Housing and Urban Development (all federal agencies) and the state of Massachusetts. These programs provide for the costs of labor and materials for the weatherization of thousands of homes and apartments in the Commonwealth each year. Weatherization leads to more efficient fuel use, reduces the utility bills of participating low-income families, and acts as a preventive measure against abandonment. In FY85, the state-funded program provided for the weatherization of approximately 3,107 housing units for families whose income did not exceed 175% of the poverty level, at a cost of \$4 million.

C. Support For Working Parents

o Health Insurance Coverage for the Newly Employed

The prospect of inadequate health coverage and the high costs of health care are major obstacles for clients in leaving AFDC and remaining employed. When a client becomes employed and leaves the AFDC caseload, she loses automatic entitlement to several services, in particular Medicaid, the health insurance program for low-income families. Even though a client has greater disposable income after becoming employed, health care is extremely costly. A parent may feel she is unable to afford health insurance and thus is confronted with the choice of foregoing necessary medical and preventive care for her children, or paying large out-of-pocket medical expenses.

Under federal guidelines, the Department of Public Welfare provides 3 months of Medicaid coverage to clients who lose their eligibility for AFDC due to the receipt of, or increase in, earnings from employment. In addition, the Deficit Reduction Act of 1984 (DEFRA) permitted extended Medicaid coverage for an additional 9 or 15 months to families who lose their eligibility for AFDC because of loss of the earned income disregard.

The DEFRA provisions, however, only help a small percentage of cases leaving the AFDC caseload because of employment. In FY87, the Department is requesting \$1.4 million to ensure that all AFDC clients who become employed through the ET program receive continuing and comprehensive health care for one year from the date they become ineligible for public assistance. Specifically, after all Medicaid benefits are exhausted, the Department proposes to purchase enrollment in a health maintenance organization (HMO) or other coordinated health plan for one year, or contribute an equivalent amount toward the purchase of traditional health insurance coverage, for ET graduates who do not receive coverage through their employers.

ET Health will provide coverage to approximately 2,250 families in FY87 and help to ensure that the high costs of health care are not a barrier to remaining employed.

o Day Care

One of the most formidable barriers to employment for all parents, but in particular single parents, is the lack of affordable child care.

Since FY84, Massachusetts has increased the supply of quality, affordable child care for low-income families by:

- Expanding the number of state funded child care slots for low-income families from 18,639 in June 1983 to 23,450 in June 1986 -- a 26% increase.
- Becoming one of only a few states to appropriate state funds specifically for the child care expenses of AFDC clients participating in an employment and training program. Since ET began in October 1983, over \$31 million has been appropriated to provide day care vouchers to participants and graduates of the ET program. In FY86, an average of 5,258 children per month will receive services through the voucher day care program.
- Extending the eligibility of ET graduates for voucher day care from 3 months to one year in FY85, in an effort to help clients remain self-sufficient in the first critical transition year from welfare to self-sufficiency.
- Ensuring the quality of child care by increasing the wages of child care workers, providing funds for 23 additional licensors at the Office for Children, and negotiating with insurance companies to continue providing liability insurance coverage to family day care homes.
- Funding 5 new Child Care Resource and Referral Agencies (CCRRs).

Massachusetts made these advances even in the face of a 21% funding cut in 1981 by the federal government in Title XX, the Social Services Block Grant. Title XX is the major source of direct federal funding for child care for low and moderate-income families, and in Massachusetts helps pay for the Department of Social Services' contracted day care system. A Children's Defense Fund survey found that the 21% cut in Title XX triggered equivalent or greater cutbacks in child care services in 32 of 46 states surveyed. Massachusetts was one of only 12 states in the country to actually expand the number of children served since 1981.

Massachusetts can be justifiably proud of the progress it has made since FY83 in filling in some of the gaps in programs for poor people created by the 1981 federal budget cuts. Many of the families most adversely affected by these cuts are the working poor -- families who struggle to make ends meet on meager and inadequate incomes. By stepping in and funding critical health and nutrition programs, providing housing and energy assistance, and supporting working parents, Massachusetts has kept its commitment to provide opportunity for all.

INTRODUCTION TO CASH ASSISTANCE

The Department delivers cash assistance and food stamps to more than 450,000 individuals each month. The adequacy of this assistance is one of the most important problems facing the Commonwealth and its poor families. The progress the Department and the administration have made in this area are described in the preceding special report on anti-poverty initiatives. This section contains narratives on each of the Department's programs of cash assistance and the accounts which fund them. These accounts are listed below:

- o Aid to Families with Dependent Children (4403-2000)
- o General Relief (4406-2000)
- o Supplemental Security Income (4405-2000)
- o Food Stamps (4400-1200)

In addition, this section contains a review of caseload trends in the AFDC program between 1983 and 1986.

AID TO FAMILIES WITH DEPENDENT CHILDREN (4403-2000)

	<u>FY83</u>	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures	\$419.3M	\$420.8M	\$432.1M	\$477.3M	\$529.9M
Average Monthly Caseload	91,355	87,534	84,391	85,356	84,822
Average Monthly Recipients	262,312	249,727	237,912	237,664	236,489

The AFDC program is a 50% federally funded, state-administered program of cash assistance to low-income families and children. In FY87, this program will serve an average of 85,000 low-income families, including 150,000 children, each month. In order to qualify for AFDC, a family must have a dependent child with an absent, deceased, disabled or unemployed parent. In addition, pregnant women with no other dependents also qualify for AFDC. Families must also meet financial eligibility requirements, including income and asset tests. Most AFDC families rely on the AFDC grant to meet their basic needs. Over 88% of all AFDC families have no income other than their monthly grant and Food Stamp benefits.

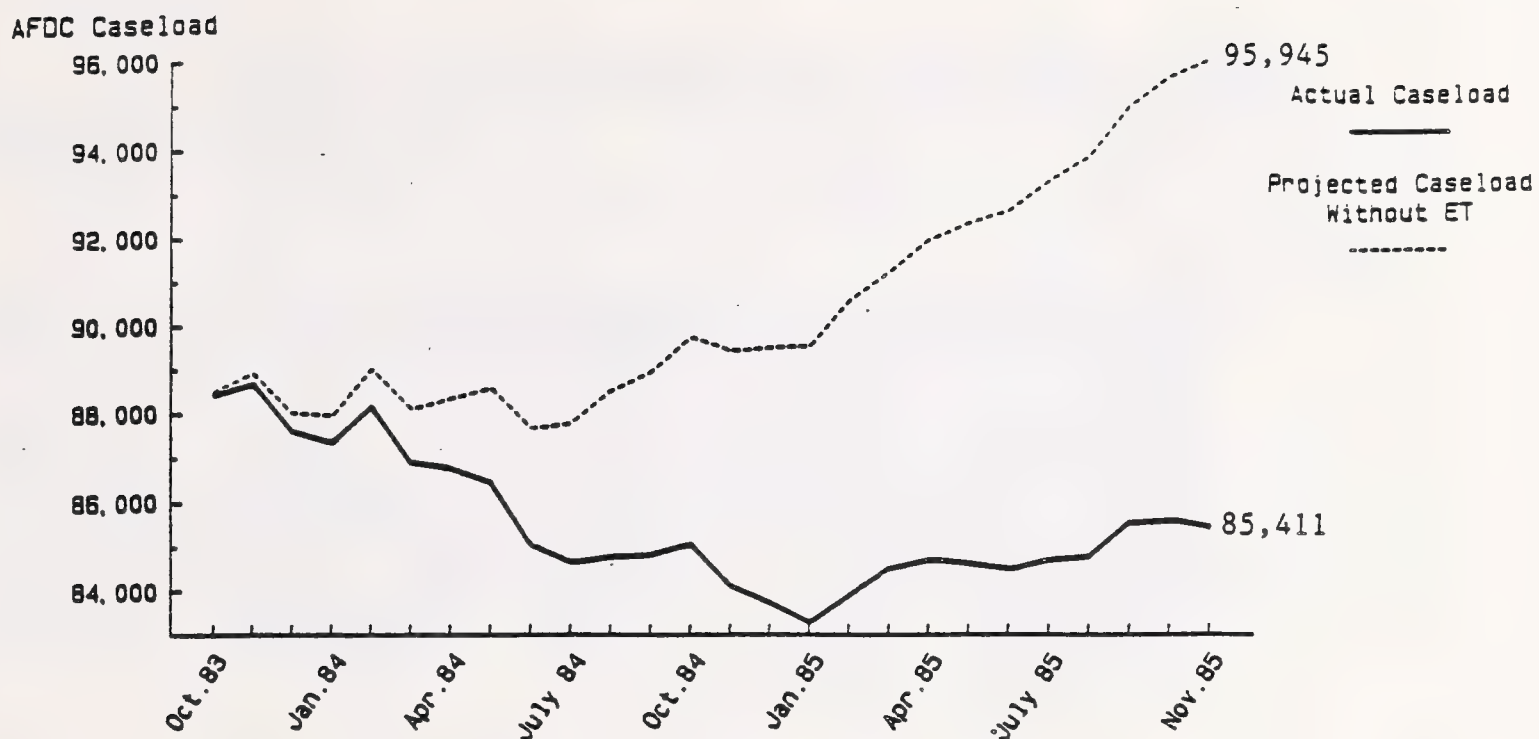
FY84 to FY86 PERFORMANCE

Since FY84, the Department has made a major effort to expand the economic opportunities available to low-income AFDC families. Key achievements are described below.

A. Employment and Training Choices Program -- 23,000 Job Placements

The Massachusetts Welfare Department has pioneered a creative employment and training program for welfare recipients called ET Choices. This program helps welfare recipients to obtain employment by providing them with education, training, job search services and day care. Since its inception in October 1983, ET has placed over 23,000 AFDC recipients into full or part-time jobs, at an average starting wage in full-time jobs of over \$5.00 per hour -- more than twice the monthly grant for an AFDC family of 3. To date, the ET program has resulted in net savings to the Department of \$69 million through caseload reductions.

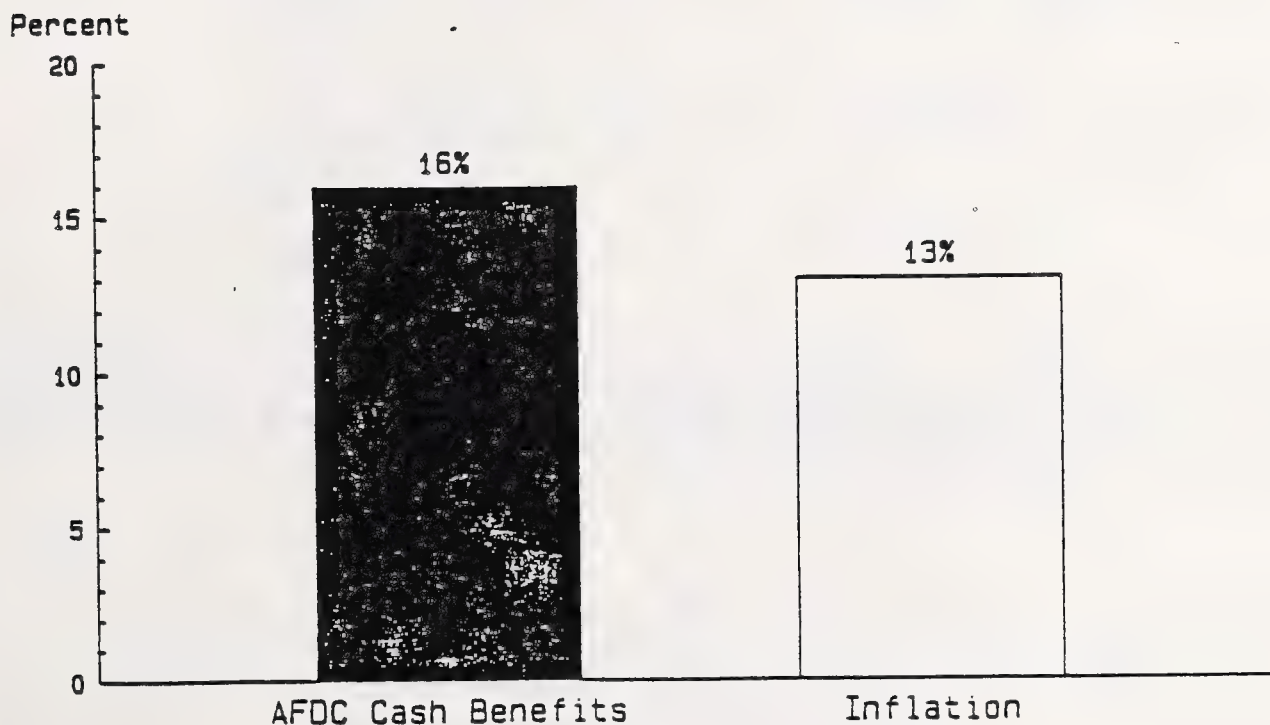
EFFECT OF ET ON THE AFDC CASELOAD



B. Improvements in Benefit Levels

Over the past 3 years, the administration and the legislature have provided benefit increases which, for the first 3 year period in more than 15 years, more than kept up with inflation. As shown below, in the first three years of the current administration, grants were increased by 16% -- 3% above that period's inflation rate of 13%.

AFDC Grant Increases V Inflation FY84 - FY86

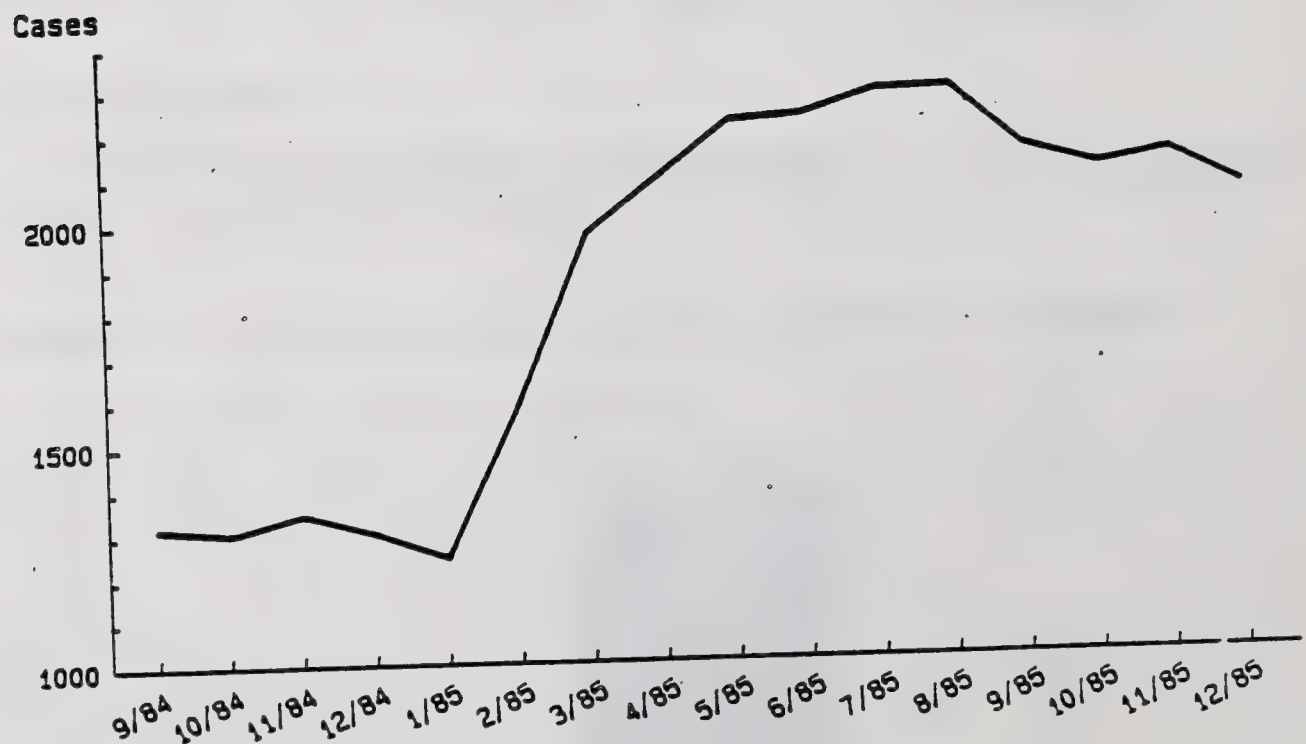


C. Expanded Eligibility For Vulnerable Populations

With the help of the legislature, the current administration has developed programs to address specific critical needs within the AFDC population. These include:

- o Extended Assistance to Pregnant Women who have no other dependents and who are in their first or second trimester of pregnancy, as provided for by Chapter 398 of the Acts of 1984. This program is intended to prevent medical complications which cause permanent damage to children born to low-income women. AFDC had been available to all pregnant women until 1981, when the Reagan administration made them ineligible for AFDC until the third trimester of pregnancy, as part of the Omnibus Reconciliation Act of 1981. Since passage of Chapter 398 in January, over 1,000 additional pregnant women per month have received assistance.

**Pregnant Women With No Other Dependents
September 1984 to December 1984**



- o Extended Eligibility for the Working Poor through two 5% standard of need increases in FY84 and FY85. In addition, the Deficit Reduction Act of 1984 made it easier for working poor families to qualify for assistance by extending the \$30 earnings disregard from 4 to 12 months.
- o Family Reunification Benefits, offering continued assistance to families whose children are temporarily placed in state care, so that families do not become homeless as they prepare for the return of their children.
- o Supplemental Payments to protect clients with earnings from fluctuations in their monthly income due to the federally mandated retrospective budgeting process. Under the prior policy, a client who lost her job might have to wait as much as two months until her grant was increased to reflect her lower earnings level.
- o Emergency Assistance Reform (Chapter 450)

Passed in October 1983, Chapter 450 of the Acts of 1983 dramatically expanded the Emergency Assistance program to provide greater guarantees against homelessness. As a result, expenditures increased from \$7.5 million in FY83 to \$22 million in FY85, and an estimated \$34 million in FY86. Key reforms include:

- eliminating restrictive caps on payments for utility and rent arrearages, advance rent and security deposits, and hotel and motel stays;
- authorizing Emergency Assistance for the prevention of homelessness during certain critical situations such as residential over-crowding or violence against a family member;
- extending eligibility for Emergency Assistance to pregnant women in their first and second trimester of pregnancy.

D. Improved Child Support Services

86% of AFDC families are single-parent families. Despite the fact that most of these families are potentially eligible for Child Support, only a minority (18%) receive child support payments each month. If fathers met their moral and legal obligation to care for their children, AFDC families could leave poverty and AFDC rolls could be dramatically reduced. ✓

In recognition of the key role that child support can play in preventing families from becoming poor and in moving poor families out of poverty, the Welfare Department, the Massachusetts legislature, the courts, and other agencies have:

- o increased child support collections to a record \$45 million in FY85, 13% more than in FY83, despite the fact that the AFDC caseload declined by nearly 10% over the same period;
- o established, through Welfare Department staff and local courts, 12,471 new child support orders in FY85 for AFDC families, and located 7,691 additional absent parents in FY85;
- o begun a new federally mandated program which allows AFDC families to keep the first \$50 of child support collected on their behalf without reducing their benefits;
- o initiated contracts between the Welfare Department and private collection agencies to locate more absent fathers and collect child support arrearages;
- o collected a larger proportion of total AFDC costs in child support collections than any of the 12 largest welfare states;
- o passed legislation in 1983 authorizing automatic wage withholding for parents who are delinquent in child support payments. Other legislation is now pending to further improve the child support collections process. ..

E. Management Improvements

Over the past 3 years, the Department has made major improvements in both the efficiency and the accuracy of the program. Key improvements include:

- o reducing the AFDC error rate from almost 12% in FY83 to 3% in FY85, the Commonwealth's lowest rate ever,
- o implementing a computerized vendor payment system in November 1985 to better monitor payments to vendors and manage EA spending,
- o designing a new computer eligibility system, MPACS, which will go into operation in FY87. This system will substantially improve the Welfare Department's capability to:
 - further improve payment accuracy and reduce error rates;
 - free workers to better manage the delivery of services to clients;
 - afford clients greater access to all welfare programs for which they are eligible.

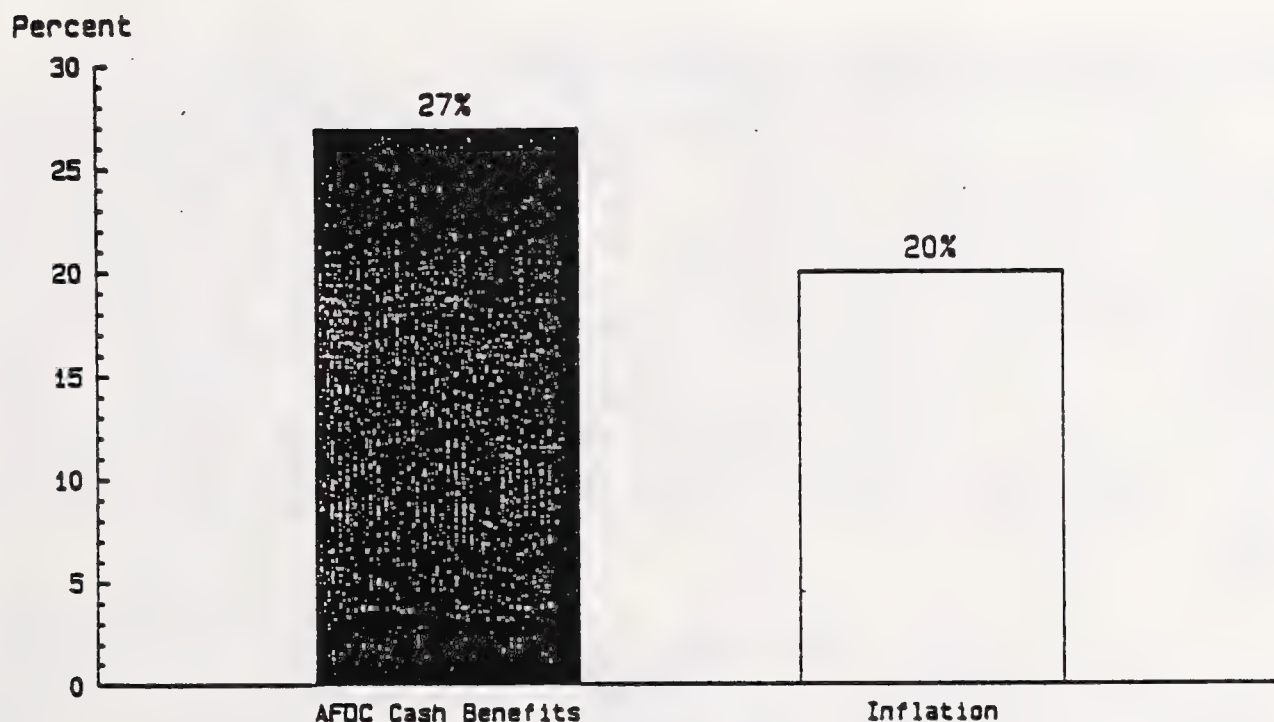
FY87 INITIATIVES

In FY87, the Department will continue to maintain the initiatives summarized in the first section of this report to enhance the economic opportunities available to welfare clients. In addition, it has requested funding for the following two initiatives for FY87:

A. 10% Cost of Living Increase

In order to further improve the adequacy of AFDC grant levels, the administration is proposing a 10% cost-of-living increase for all AFDC families. The total cost of this initiative of \$44.9 million is more than offset by estimated ET savings to date of \$69 million. The 10% CoL increase will increase the maximum payment for an AFDC family of 3 from \$432 to \$476. This increase will bring the cumulative cash benefit increase since FY83 to 27%, as compared with inflation during the period of 20%. With the 10% cost-of-living increase, cash and Food Stamps benefits for an AFDC family of 3 will increase from 82% of the poverty line in FY86 to 84% in FY87.

AFDC Grant Increases V Inflation
FY84 - FY87



B. ET Expansion -- 10,000 More Job Placements

In FY87, the Department will continue to stress its basic ET programs: career planning, supported work, skills training, and job placement. These programs have placed over 23,000 AFDC families into full or part-time jobs, and saved the Department an estimated \$69 million through caseload reductions. Through the ET program, the Department plans to place an additional 10,000 AFDC families into unsubsidized employment in FY87. In addition, the Department is planning to implement new ET programs to reach the least job-ready members of the AFDC population, including:

- o An Adult Literacy program to help AFDC recipients who have not completed high school to get the basic education skills that they need to locate employment.
- o A Pregnant and Parenting Teens program, offering day care, career counseling, and employment experience, to help young mothers locate employment.

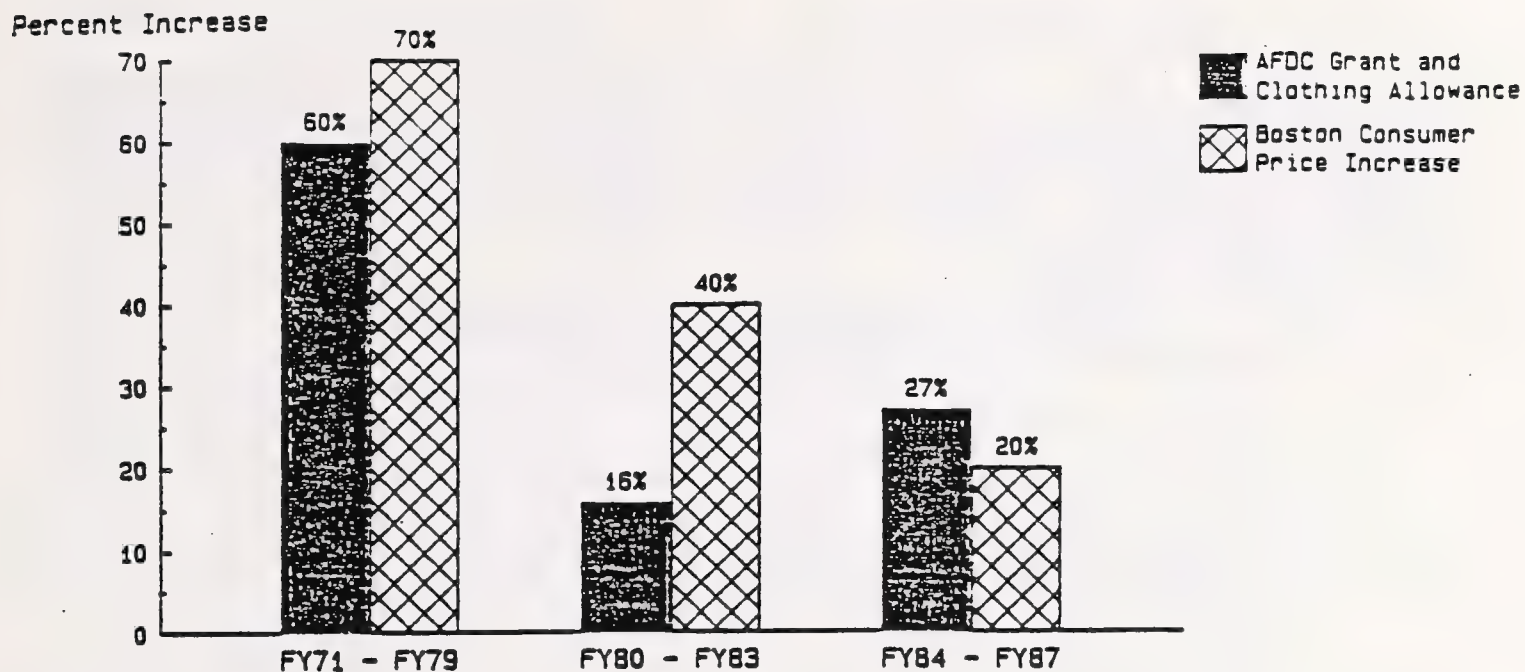
In addition, in an effort to help recipients remain in their jobs once they have located employment, the Department will offer ET graduates transitional counseling services and extended medical benefits, through its ET Health Choices program.

INFLATION AND THE ADEQUACY OF GRANT LEVELS

As a result of more than a decade of grant increases which did not keep pace with inflation, the real value of the AFDC grant and Food Stamp benefits deteriorated severely. From FY71 to FY79, the real value of AFDC and Food Stamp benefits declined but remained close to the poverty line. From FY80 to FY83, however, the value of welfare benefits markedly declined. From FY80 to FY83, prices increased 40%, as indicated by the Boston C.P.I. In the same period, AFDC benefits increased by a total of only 16%. By the end of this period, prices had increased three times faster than the Commonwealth had increased monthly AFDC grants. As a result, the real value of AFDC and Food Stamp benefits decreased from 100% of the poverty line in FY79 to nearly 20% below the poverty line in FY83.

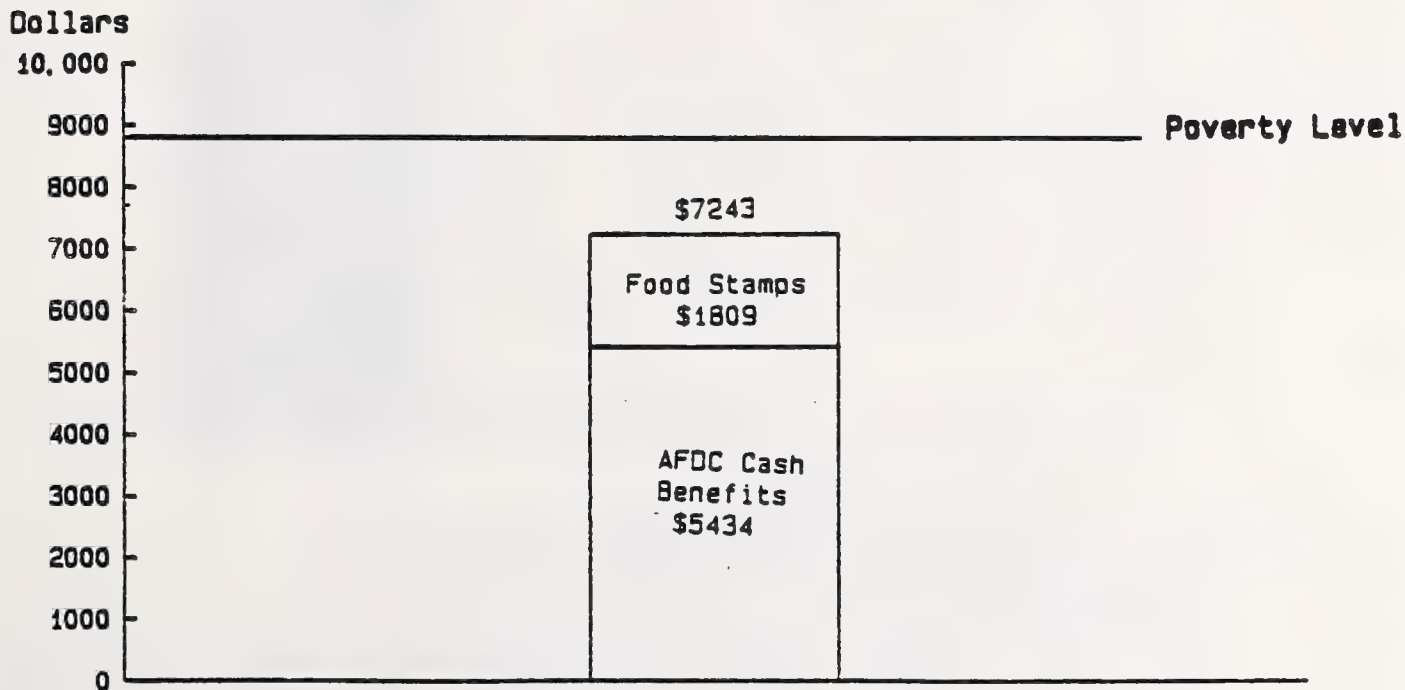
More recently, grants have more than kept up with inflation. From FY84 to FY86, the Department increased grants by 16%, as compared with inflation during the period of 13%. With the proposed 10% increase in FY87, from FY84 to FY87, the Department will have increased grants by 27% -- 7% above the inflation rate during the period of 20%.

AFDC Grant Increases V Inflation FY71 - FY87



Even with the relatively high grant increases from FY84 to FY86, which represented the first three year period in more than a decade in which grants more than kept up with inflation, the adequacy of the grant is still a problem. As shown below, the value of the maximum cash and Food Stamp benefits available to an AFDC family of three is still 18% below the poverty level in FY86.

FY86 Maximum AFDC & Food Stamp Benefits For a Family of Three



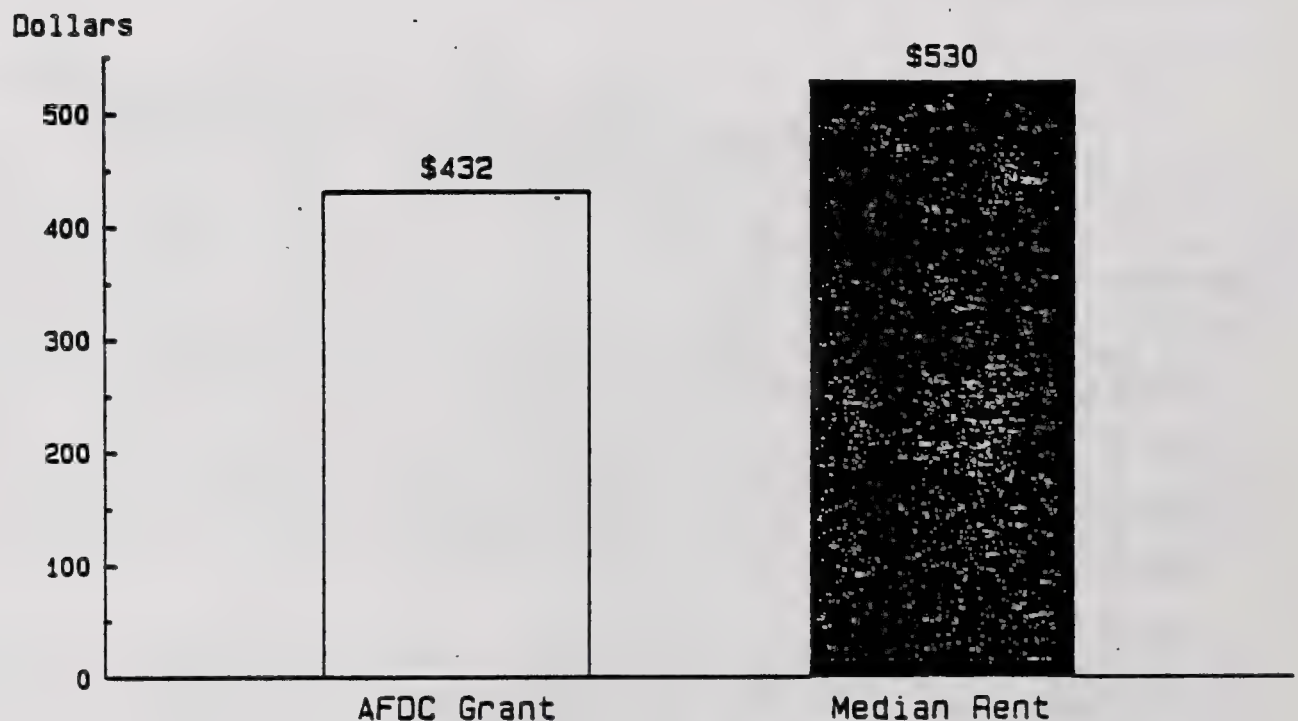
RESULTS OF INADEQUATE GRANT LEVELS

For the nearly 90% of AFDC families whose only source of income is the AFDC grant, the dangers of living on an inadequate grant are acute, creating a dangerous climate of poverty and family instability in which a number of problems threaten the well-being of parents and children. These problems include:

- o Increased Risk of Homelessness and Destitution

Most AFDC recipients do not have an adequate income to compete successfully for housing in the tight private housing market. Currently, the median rent of housing units in Boston of \$530 is above the entire \$432 monthly grant for an AFDC family of 3. As a result, families devote a disproportionate share of their income to housing, scrimping on other necessities such as food and clothing. Currently, AFDC recipients spend 70% of their AFDC grant on fuel and housing, leaving the remaining 30% to cover all other necessities. Often this level of housing expenditures cannot be maintained and families become homeless.

**Boston Median Rent V AFDC Grant
for a Family of Three**



- o Increased Reliance on Emergency Assistance

When the monthly cash grant is insufficient to pay bills, families sometimes must let bills accrue until an Emergency Assistance claim can be made. From FY83 to FY85, the number of families using EA nearly doubled, despite a caseload decline of 4%. This may be because more families are using Emergency Assistance as a regular source of income rather than as a safeguard against emergencies.

ELEMENTS OF THE AFDC PROGRAM

The single major activity of the AFDC program -- 85% of total AFDC expenditures -- is the provision of monthly cash grants to poor families with children. Other components of the AFDC program include the Emergency Assistance program and a range of targeted assistance programs. To qualify for AFDC, a family must have a dependent child with an absent deceased, disabled or unemployed parent. Families must also meet the program's financial eligibility requirements. For example, a family of 3 must have a monthly income of less than \$800 and assets of less than \$1,000. More detail on AFDC is provided below.

A. Cash Assistance

To be eligible for cash assistance, families must meet the program's categorical and financial requirements. These are outlined below.

o Categorical Eligibility

There are two principal components of the AFDC program: the Basic and the Unemployed Parent components. The Basic program assists single-parent families or two-parent families in which one parent is disabled. The Unemployed Parent program assists intact families in which the principal earner is unemployed. While virtually all states have Basic AFDC programs, only 25 states have an Unemployed Parent program.

The major categorical requirement of the Basic component of AFDC is that the family must have a dependent child who is deprived of the economic support of at least one parent. A child can become deprived of support through the death, disability or continued absence of a parent. Federal regulations define a dependent child as any child under the age of 18, or a child under 19 who is in high school or technical or vocational school, and who is expected to have graduated before his or her nineteenth birthday. In addition, pregnant women with no other dependents also qualify for AFDC. Pregnant women in their first or second trimester of pregnancy had been cut from the AFDC program by the Reagan Administration in 1981. Since then, state legislation has again made this group eligible for AFDC, solely at state cost.

The major categorical requirements of the Unemployed Parent component of AFDC are that the principal wage earner must:

- currently be unemployed or have been employed less than 100 hours during the month preceding the date of application;
- have a work history that meets the program's requirements;
- have been denied or have exhausted unemployment benefits; and
- have registered for the Employment and Training (ET) Program.

The principal wage earner is the parent with the greatest earnings in the 24 months preceding application.

o Financial Eligibility

Families that are categorically eligible for either the Basic or UP component must also meet the program's financial eligibility requirements regarding assets and income. These requirements are described below.

First, a family's total assets must be less than \$1,000. Assets include cash on hand, bank deposits, securities, insurance policies, real estate equity other than the family's home, and any equity in an automobile over \$1,500.

Second, the family must meet restrictions on total income. Three income standards are used to determine eligibility and payments. They include:

- Payment standard: The maximum monthly grant the state will pay to families of various sizes.
- Standard of need: The amount the state has designated as being required to maintain families at a near-subsistence level.
- Eligibility standard: The maximum amount of gross income that a family can earn and still be eligible for AFDC.

The levels of both the payment standard and the standard of need are established by the Massachusetts legislature. The level of the eligibility standard is set by the federal government at 185% of the standard of need.

In order to receive an AFDC grant, a family must meet two income-based requirements. First, its gross income must not exceed the eligibility standard, and second, its net income, after all deductions are taken, must not exceed the standard of need. Deductions include:

- a work-related expense deduction, of \$75 per month for all families with earnings;
- a child-care expense deduction of up to \$160 per child per month, or actual expenses, whichever is less; and
- a work-incentive disregard, commonly called "\$30 and a third", which disregards the first \$30 of a recipient's net income for twelve months, and one-third of the remainder for four months. This disregard is intended to ease the transition to work by avoiding a one-to-one offset of increases in earnings with reductions in welfare payments.

The following chart summarizes the current levels of the payment standard, the standard of need, and the eligibility standard. As it indicates, a family of three would qualify if its monthly gross income fell below \$812, and its monthly net income, after

all deductions are taken, fell below \$439. The maximum AFDC payment for a family of three is \$432 per month.

FY86 PAYMENT STANDARD, NEED STANDARD AND ELIGIBILITY STANDARD

Assistance Unit Size	Payment Standard	Standard of Need	Eligibility Standard
1	\$282	\$287	\$530.95
2	358	365	675.25
3	432	439	812.15
4	505	515	952.75
5	579	591	1,093.35
Incremental	79	76	140.60

o Determining the Amount of the AFDC Grant

Once eligibility is determined and all deductions are taken, the amount of the grant is calculated by comparing the recipient's net income to the need standard. To calculate the grant, net income is subtracted from the need standard. If the result is between \$0 and \$10, the applicant will not receive a check, but will be automatically eligible for Medicaid and Emergency Assistance, and the September clothing allowance of \$125 per dependent child. If the result is more than \$10, but less than the payment standard, the applicant will receive the full amount of the calculation. In no case may an AFDC family receive more than the amount of the payment standard for the relevant family size. The table below illustrates how grants are calculated for three hypothetical families of size three with different net incomes.

EXAMPLES OF GRANT CALCULATIONS FOR A FAMILY OF 3

	Family A	Family B	Family C
Need Standard	\$439	\$439	\$439
Net Income	<u>-430</u>	<u>-200</u>	<u>-0</u>
Difference	9	239	439
AFDC Payment	\$ 0*	\$239	\$432**

* Federal regulations prohibit providing cash assistance to anyone whose monthly benefits would be \$10 or less.

**The payment standard limits these benefits to \$432, although the difference between net income and the standard of need is greater.

B. Emergency Assistance

The Emergency Assistance program is a program of temporary assistance for low-income families in crisis situations such as a natural disaster, homelessness, imminent eviction or utility shut-off. Services provided through this program include:

- o payment for up to four months of utility or rent arrearages for families in danger of eviction or utility shut-off;
- o payment for one month's advance rent and a security deposit to help homeless families locate a new apartment; and
- o up to 90 days lodging in a hotel and motel for homeless families with no other housing alternatives.

The chart on the following page provides more information on the services authorized under this program.

To qualify for Emergency Assistance, gross income must be less than the eligibility standard. For instance a family of three must have a gross monthly income of less than \$812. In addition, the family must meet the following categorical requirements: first, either pregnancy, or the presence of an eligible dependent child in the home within the preceding six months; second, no EA during the past twelve months; and third, a need for one or more covered services.

EMERGENCY ASSISTANCE BENEFITS

<u>Type of Benefit</u>	<u>Amount of Benefit</u>
<u>Disaster</u>	
o Emergency Shelter	o Up to 90 days as needed.
o Advance Rent	o Amount of monthly rental charge.
o Security Deposit	o Amount of monthly rental charge.
o Moving Expenses	o Actual cost or \$150, whichever is less.
o Bedroom Furniture	o \$175 per person.
o Kitchen Furniture	o \$107 for a family of 4 or fewer. \$23 per each additional member.
o Refrigerator	o \$224 for a family of 5 or fewer. \$308 for a family over 5, when not furnished by the landlord.
o Stove	o \$229 plus installation, when needed.
o Hot Water Heater	o \$191 plus installation, when not furnished by landlord.
o Household Equipment	o \$68 for each of first two people. \$23 per additional person.
o Furniture Storage	o Actual cost of up to 30 days of storage.
o Clothing	o \$80.90 per person.
o Food	o \$41.80 per person.
<u>Homelessness and Prevention of Homelessness</u>	
o Emergency Shelter	o Up to 90 days as needed.
o Advance Rent	o Amount of monthly rental charge.
o Security Deposit	o Amount of monthly rental charge.
o Moving Expenses	o Actual cost or \$150, whichever is less.
o Furniture Storage	o Actual cost of up to 30 days storage.
<u>Arrearages</u>	
o Rental, gas, electric and oil arrearages	o As needed for any debts incurred in 4 months prior to application for EA.
o Delivery of home heating oil	o One delivery.
<u>Appliance Repairs</u>	
o Repair or replacement of refrigerator, stove, or hot water heater	o Up to \$100.

C. Targeted Services

In addition to the monthly cash grant and Emergency Assistance, the Department offers a range of targeted programs to assist low-income families. These programs are described below.

- o \$125 September Clothing Allowance. Each year for the past five years the Massachusetts legislature has approved a clothing allowance for each dependent child receiving assistance in September to help AFDC families buy additional clothing for their children's return to school. This benefit was initially \$50 per dependent child in FY82, and was raised to \$75 in FY83, and to \$125 in FY84. The Department is requesting a \$125 clothing allowance for FY87.
- o Family Reunification Benefits. As mandated by Morin v. Atkins, and authorized by the legislature, the Department pays AFDC benefits to parents whose children are temporarily placed in state custody for up to 6 months after the child is removed, and for the 3 months prior to the return of the child to the home. This program is intended to prevent families from becoming homeless as they prepare for the return of their children.
- o Supplemental Benefits. Under existing federal regulations requiring monthly income reporting and retrospective budgeting of AFDC grants, the amount of the monthly grant of families with earnings must be based upon income reported in a previous month. Thus, if an AFDC recipient's income suddenly declines due to the loss of a job or reduction in hours worked, she must often wait up to two months to receive a compensating increase in her AFDC grant. This causes hardship for low-income families, who have little margin for a sudden drop in income. To address this problem, the Department offers supplemental benefits to families whose income suddenly declines to make up for the loss in income during the period before their regular AFDC check increases.
- o Child Support. Under the Child Support program, the Department of Public Welfare assists mothers in locating absent fathers, establishing paternity and child support orders, and enforcing payment each month. As permitted by the federal Deficit Reduction Act of 1984, the first \$50 of child support collected is paid directly to recipients. Remaining child support collections are retained by the Department and offset AFDC expenditures, reducing federal and state costs. However, when the amount of child support collected on behalf of a family exceeds the amount of the grant, the recipient becomes ineligible for AFDC, and child support payments are made directly to her, increasing her total income.
- o Employment and Training and Day Care. Under the Employment and Training program, recipients may participate in basic education, skills training, job referral, career counselling and supported work programs. All ET participants are eligible for day care benefits for the period that they participate in the program, as

well as for the 12 months immediately following job placement. In addition, ET graduates who are placed in jobs without employer health insurance receive coverage in an HMO for to 12 months after they are placed into a job.

- o Medicaid. All AFDC recipients are automatically eligible for Medicaid. This program entitles recipients to comprehensive health care, including inpatient and outpatient hospital care, mental health services, dental care, and preventive health services for children. The Department also offers two special health care programs -- Project Good Health, a preventive health care program, which offers comprehensive and continuing health care to Medicaid recipients under age 21; and the Coordinated Health Program, a coordinated approach to service delivery which offers health care through community health providers and health maintenance organizations.

RECENT FEDERAL AND STATE INITIATIVES

The federal government and the state each pay for 50% of AFDC expenditures, and each plays a key role in shaping the AFDC program. The federal government establishes many basic eligibility rules, whereas the state determines payment and need standards and can supplement federal programs with state-funded initiatives. Two of the most important recent federal initiatives are the Omnibus Budget Reconciliation Act of 1981 and the Deficit Reduction Act of 1984. Major state reforms include Chapter 450 of the Acts of 1983, the homelessness statute, and Chapter 398 of the Acts of 1984, which extended eligibility for AFDC to pregnant women in their first or second trimesters of pregnancy.

A. Federal Initiatives

- o The Omnibus Budget Reconciliation Act of 1981 (OBRA)

The Omnibus Budget Reconciliation Act of 1981 dramatically changed the federal regulations governing the AFDC program. In the year immediately after its passage, OBRA resulted in at least 24,500 case closings and 11,400 grant reductions. Overall, it reduced the caseload by over 30,000 cases. Working poor families were among those most severely affected by OBRA. The total number of AFDC cases with earnings declined from 24,000 in August of 1981 to 8,500 in December of 1983. This decline of over 15,000 cases accounted for over 48% of the caseload decline over this period.

The most important OBRA changes were more stringent limits on recipients' earnings and assets and tighter categorical eligibility requirements, including:

- an absolute ceiling on recipients' gross income of 150% of the standard of need;
- restriction of the earned income disregard to four months;

- stipulation that step-parents' income must be considered in making eligibility determinations;
- elimination of aid to pregnant women in their first two trimesters of pregnancy; and
- elimination of aid to dependents between the ages of 18 and 21.

o The Deficit Reduction Act of 1984 (DEFRA)

Enacted in June of 1984, this law included over 20 provisions modifying the AFDC program. Many of these provisions liberalized the program, reflecting concern that OBRA reductions had been too severe. Some salient provisions include:

- Increase in the Gross Income Limit from 150% to 185% of the Standard of Need.

DEFRA raised the AFDC gross income limit from 150% to 185% of the state's standard of need. For example, under DEFRA, a family of 3 is now eligible for AFDC if its gross income is \$812.15, rather than \$658.50, as long as it meets the net income requirements.

- \$75 Work-Related Expense Deduction Standardization

Under previous policy, working recipients received a work-related expense deduction that was pro-rated by the number of hours worked during the month up to a maximum of \$75. DEFRA mandated that all working recipients receive the maximum deduction of \$75, regardless of the number of hours worked. This provision resulted in grant increases of between \$19 and \$56 for an estimated 6,600 AFDC recipients.

- Extension of the \$30 Earned Income Disregard

Under previous policy, prior to determining the amount of the grant, working recipients could deduct \$30 from gross income, followed by one-third of the remainder, for four months after they entered the program. DEFRA extended the \$30 disregard to twelve months and left the one-third disregard unchanged at four months. This provision thus enabled working recipients to receive an additional \$240 over eight months.

- \$50 Child Support Disregard

DEFRA requires the Department to return the first \$50 of child support collected each month on behalf of an AFDC recipient to the recipient, without instituting an offset to the individual's grant. In the first five months of

FY86, this provision resulted in an average of 15,500 payments to AFDC clients at an average of \$47.

B. State Changes

o Chapter 450 of the Acts of 1983 -- An Act to Prevent Homelessness

Passed in October 1983, Ch. 450 of the Acts of 1983 dramatically expanded the Emergency Assistance program, in order to provide greater guarantees against homelessness, and to extend eligibility to particularly vulnerable populations, such as pregnant women. These reforms are summarized in the first section of this report.

o Chapter 398 of the Acts of 1984 -- Extended Assistance to Pregnant Women

Chapter 398 of the Acts of 1984 extended eligibility for AFDC to pregnant women who are in their first or second trimester of pregnancy and who have no other dependents. This legislation enabled over 1,000 additional pregnant women per month to receive assistance. More information on this initiative is included in the first section of this report.

THE AFDC POPULATION

Each month, AFDC provides assistance to over 85,000 families or 240,000 individuals throughout the Commonwealth. AFDC families represented as much as 80% of all poor families in 1984, and 50% of all poor individuals in 1983. An estimated one in 14 Massachusetts families received AFDC in 1984.

AFDC families are in many respects not unlike other Massachusetts families. The typical AFDC parent is a 30-year old, white woman with two children. In some important respects, however, AFDC families differ from other families, and thus require additional assistance. Nearly 86% of AFDC families are headed by a single female parent. Over half of these families include a child under age six. The vast majority (88%) have no income other than their AFDC grant and thus particularly rely on AFDC for assistance.

A. Age

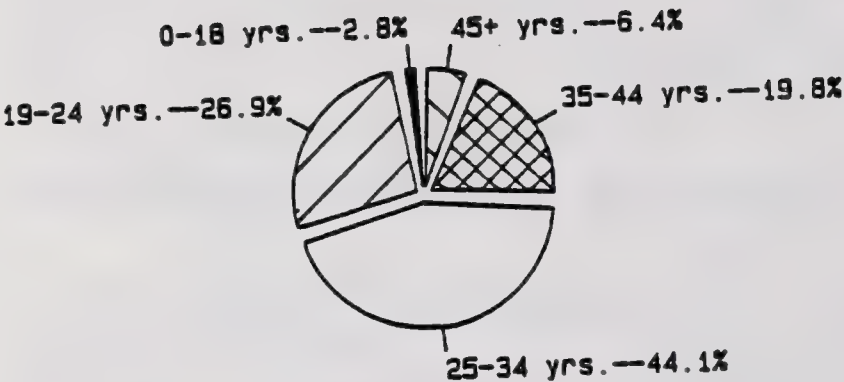
Although the popular notion is that most AFDC recipients are very young, this is not true of the Massachusetts AFDC population. The average age of all household heads is 30. Only 3% are under the age of 18 and only 30% are under 24. Over 26% of all AFDC household heads are age 35 or older.

B. Race

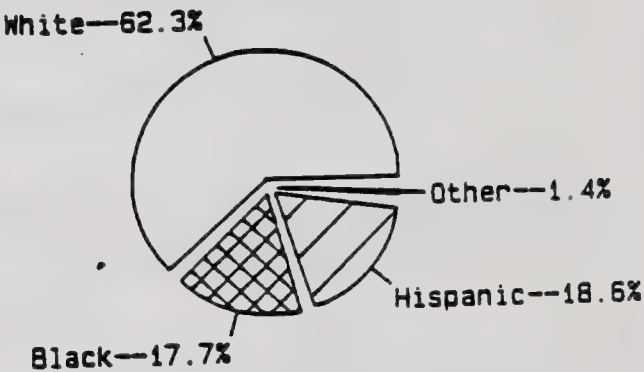
The majority (63%) of AFDC recipients are white. Of the remainder, 18% are black, 18% are Hispanic, and 1% are Asian or native American.

Characteristics of AFDC Parents

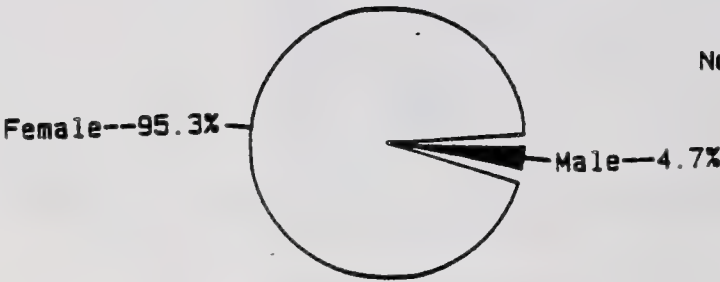
AGE



RACE



SEX



INCOME



C. Sex

95% of all AFDC parents are women, and 5% are men.

D. Income Sources

Approximately 9% of the AFDC population had earnings in November 1985. A smaller number (3%) had unearned income such as social security or workmen's compensation. The vast majority (88%) of the AFDC population, however, had no source of income other than the AFDC grant. The reliance of most AFDC recipients on the AFDC grant makes the adequacy of the grant a critical issue.

E. Family Size

The average family size for AFDC cases is 2.82, lower than the Massachusetts average of 3.32, as reported by the 1980 census.

48% of AFDC families have one child, and 77% have two or fewer children. Very few AFDC households have large families. Only 8% have more than three and 3% more than four children. As shown in the following chart, this is comparable to the number of children in all Massachusetts families. Of all Massachusetts families with children in 1980, 37% had one child and 75% had two or fewer children. 8% of Massachusetts families had more than four children.

F. Family Composition

The vast majority of AFDC cases are headed by a single, female parent (84%). Only 2% are headed by a single male parent, and 4% are two-parent families in which the principal earner is either disabled or unemployed. The remainder (10%) are households in which only the children are receiving assistance because the care-taking relative is not in need.

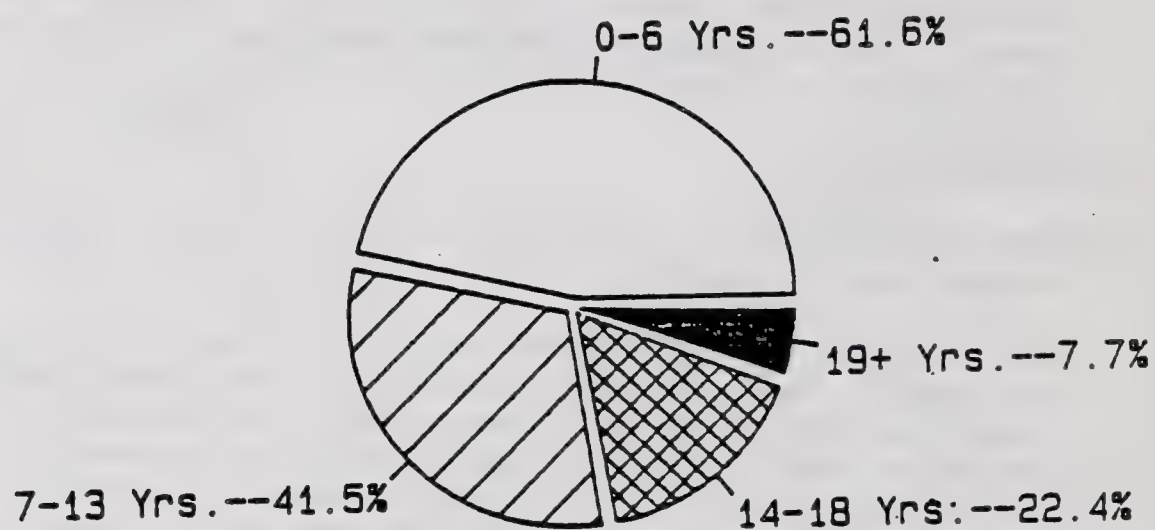
Most AFDC families (93%) have lost the support of one or more parents due to the continued absence of the parent from the home. A smaller number have lost a parent's assistance due to death (1%), incapacity (3%) or unemployment (3%).

G. Families with Young Children

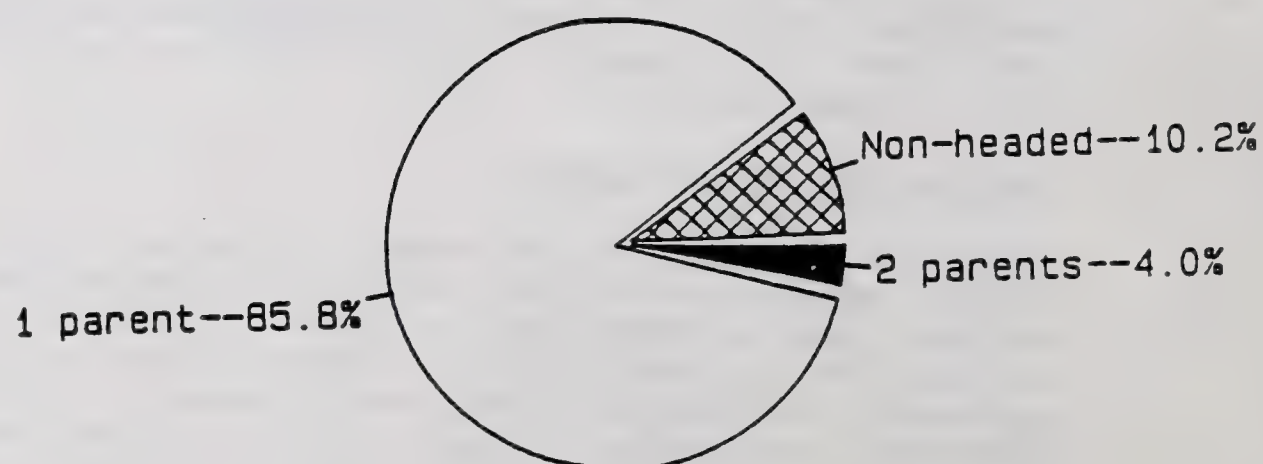
62% of all AFDC families have young children under age 6 and 42% have children between the ages of 7 and 13. Because of the high costs of day care, many of these families find it difficult both to work and to care for a young child. However, when offered day care assistance, many of these families volunteer to participate in the Department's ET program. Federal rules do not require a family with a child under the age of six to participate in an employment and training program. However, many parents of young children volunteer for ET -- 40% of all AFDC families in ET had a child under 6.

Characteristics of AFDC Families

PRESENCE OF CHILDREN BY AGE

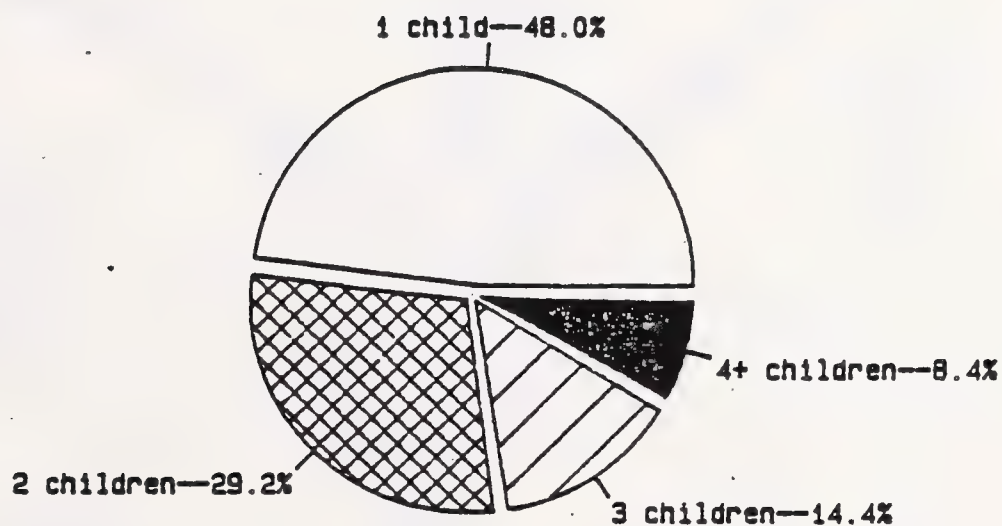


NUMBER OF PARENTS

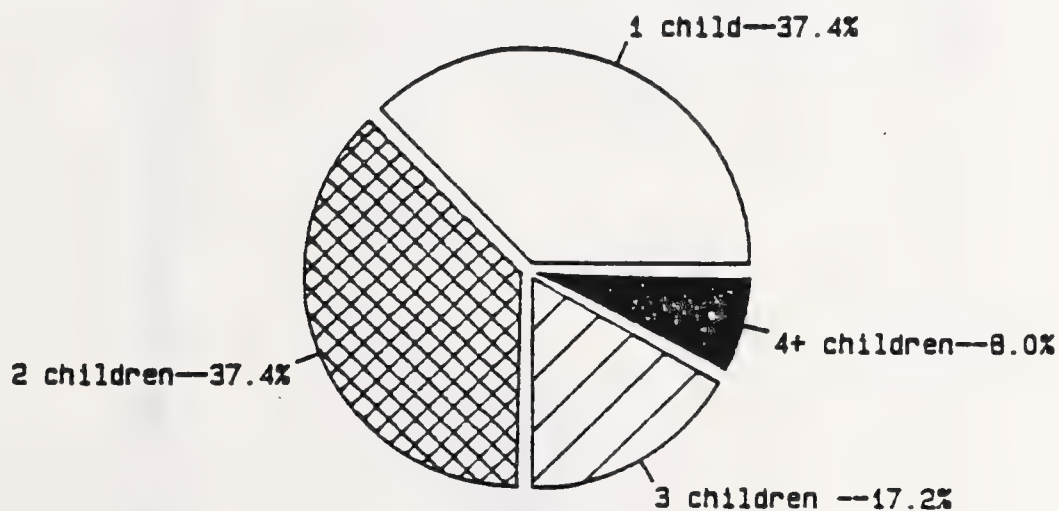


Number of Children: AFDC Families Vs. All Massachusetts Families With Children

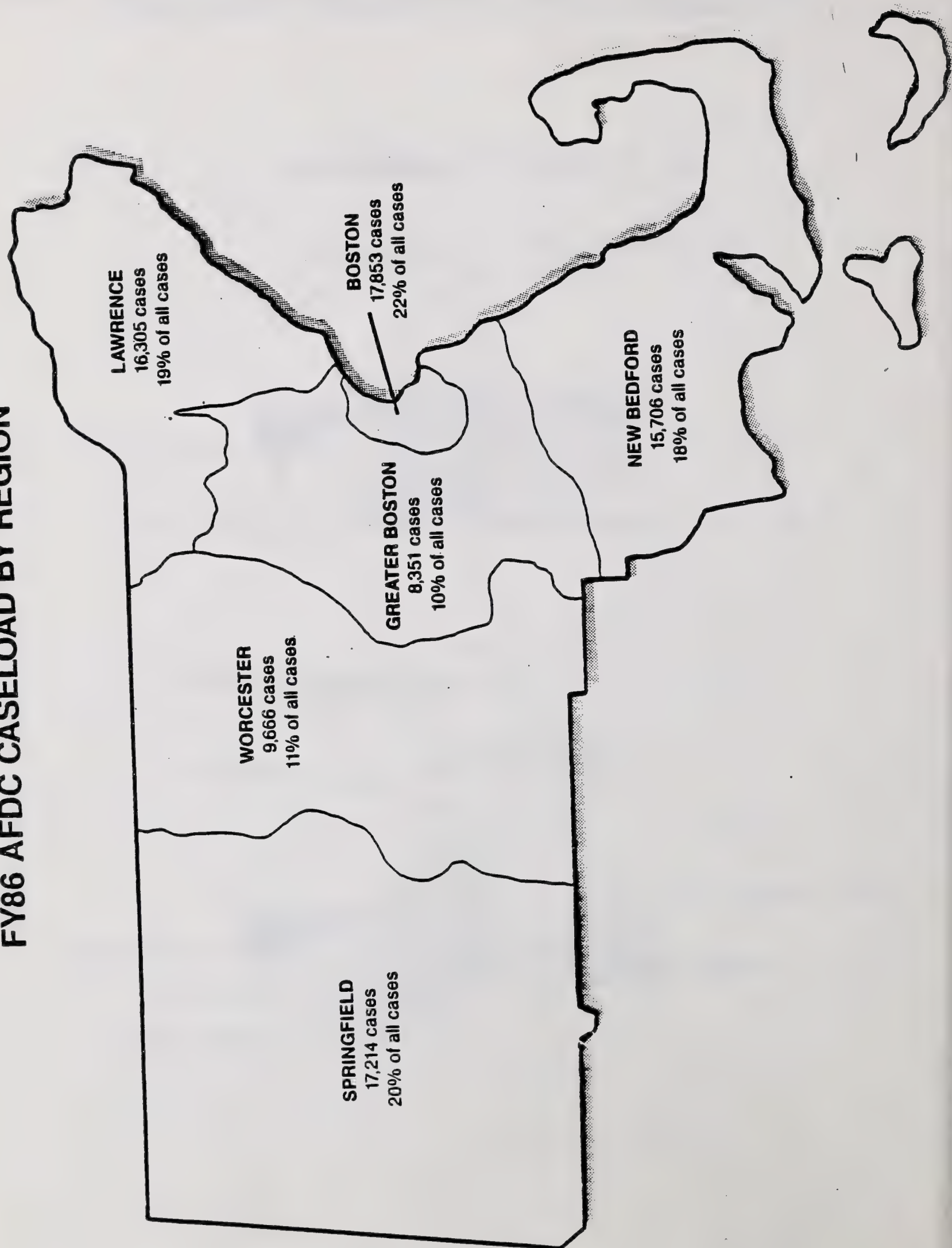
AFDC FAMILIES



**ALL MASSACHUSETTS FAMILIES
WITH CHILDREN**



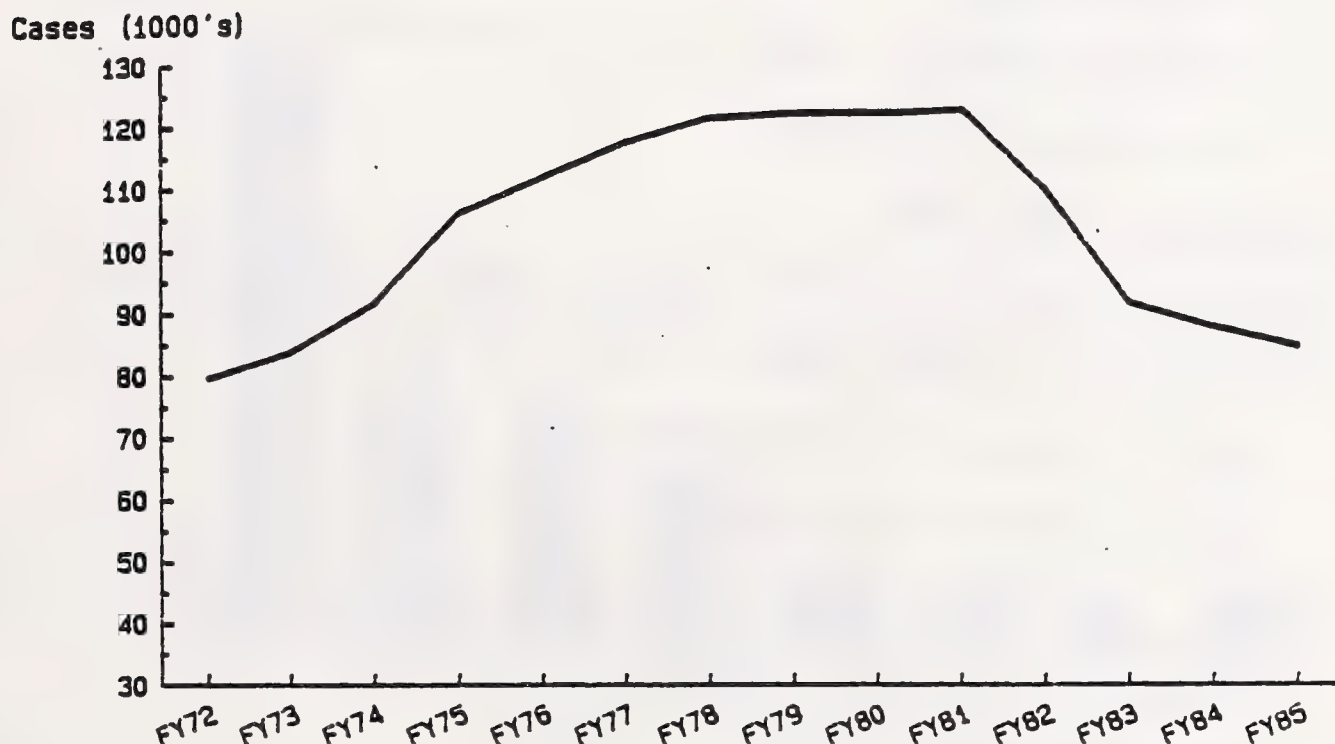
FY86 AFDC CASELOAD BY REGION



AFDC CASELOAD FY70 TO FY85

As shown below, the AFDC caseload increased throughout the 1970's, and declined in each year since FY81. The marked caseload decline between FY81 and FY83 is a result of the federal Omnibus Reconciliation Act of 1981. As noted above, this legislation dramatically restricted eligibility for AFDC, reducing the caseload by 30,000 from FY81 to FY83. The continued caseload decline since FY83 is largely due to the strong Massachusetts economy and to the Department's ET Choices program. Since October 1983, this program has reduced the AFDC caseload by placing over 23,000 AFDC parents into full or part-time positions.

**AFDC Caseload
FY72 - FY85**



AFDC DYNAMICS

Each month 4,000 families enter and 4,000 families leave the AFDC caseload. In a year as many as 40% of all cases turn over. Key elements of AFDC dynamics are described below. More information on this subject is contained in the special report in this volume on the AFDC caseload.

A. Initial Need for AFDC

Research has shown that a majority of families come on to the AFDC caseload because of a family crisis, such as divorce, separation or birth to an unwed woman:¹

- o 45% enter because a mother became divorced, separated or widowed,
- o 30% enter because an unwed woman gave birth to a child,
- o 16% enter because the family's income declined,
- o 9% enter for other reasons.

B. Why Families Leave AFDC

While most families enter AFDC due to a change in family composition, most leave by finding a job. A survey of all AFDC families who left the caseload during the summer of 1983 found that: ²

- o 52% left because they had found a job,
- o 16% left because the mother remarried,
- o 15% left because there was no longer an eligible child in the household (e.g. the dependent became older than 18, or was placed in the care of another person),
- o 17% left for other reasons.

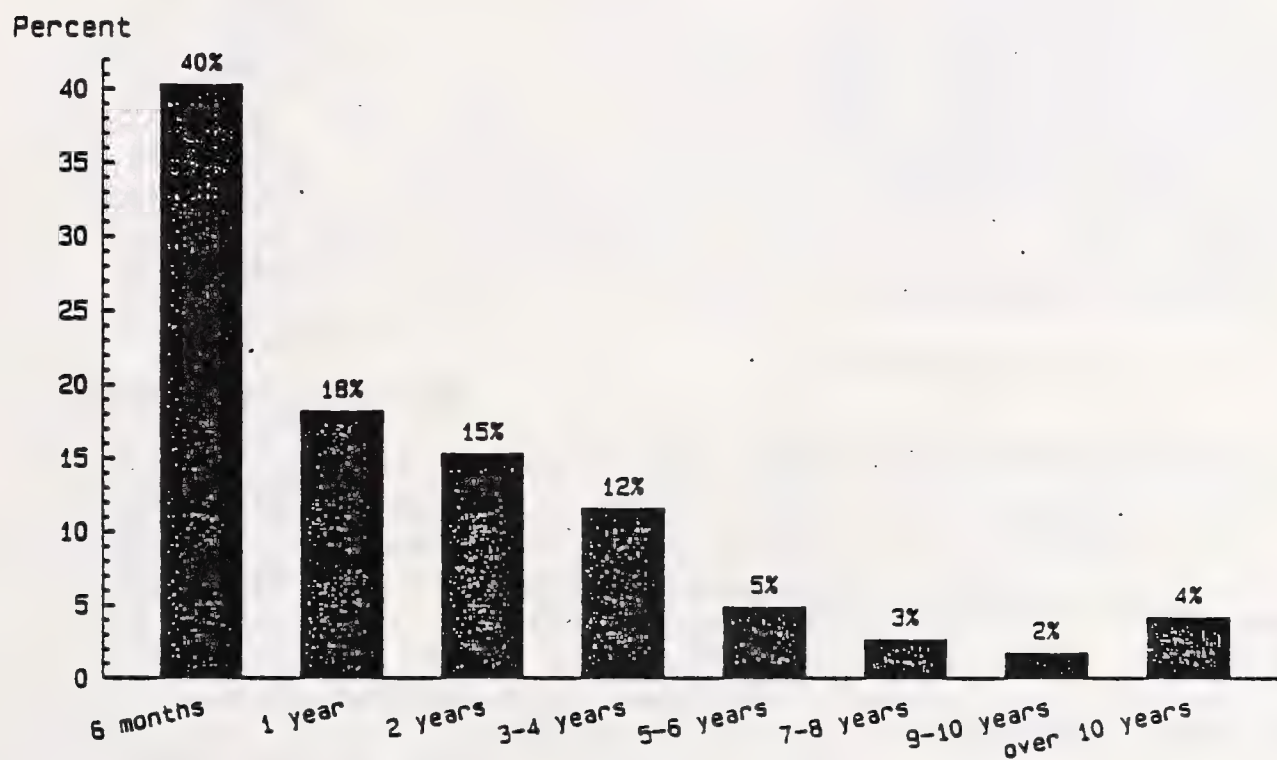
¹ Bane, Mary Jo and Ellwood, David, "The Dynamics of Dependency: The Routes to Self Sufficiency," June 1983.

² Research and Planning and Evaluation Division, Department of Public Welfare.

C. Length of Stay

Most AFDC recipients stay on the AFDC caseload for a relatively short period of time, using AFDC as a temporary source of assistance as they search for other means of support. A survey of closed cases in December 1985 found that 40% of all cases had been on the caseload for less than 6 months and 59% had been on for less than a year. Overall, the average length of stay was twenty-three months. The length of stay has declined since last year, when all closed cases had been on the caseload an average of twenty-six months.

**Length of Stay of AFDC Clients
Closed Cases, 12/85**



THE FY87 BUDGET REQUEST

The Department's FY87 request for the AFDC program totals just under \$474 million. As the federal government reimburses 50% of all eligible expenditures, the net state cost is thus approximately \$237 million.

The chart and list which follow briefly describe each item of expenditure.

<u>FY87 Request</u> <u>(in thousands of \$)</u>	
1. Direct Payments	\$407,543
2. Emergency Assistance	39,100
3. Other Non-medical Vendor Payments	12,297
4. \$125 Clothing Allowance	19,750
5. \$50 Child Support Disregard	7,466
6. Supplemental Benefits	712
7. Family Reunification Benefits	451
8. Refunds	(2,405)
9. Legal Fees	100
10. 10% Payment Standard Increase	<u>44,875</u>
Total FY87 Expenditures	\$529,889
Child Support Collections Goal	<u>\$ 56,300</u>
FY87 Request	\$473,589

1. Direct Payments \$407.5M

Direct payments are the regular monthly checks paid directly to recipients. The amount of payment is based on the payment standard, family size, and net income, reflecting total income and deductions based on client circumstances. In FY87, the average monthly grant is projected at approximately \$444 with the proposed 10% Col increase.

2. Emergency Assistance \$39.1M

Emergency Assistance payments are special services provided to recipients who face a particular emergency. Recipients served include those who have become homeless or are in danger of becoming so. Services are also available to compensate for natural disasters, and to pay for the replacement or repair of appliances.

3. Other Non-Medical Vendor Payments \$12.3M

Non-medical vendor payments are primarily advance and protective payments made on behalf of clients to service vendors. If clients need assistance in managing their grant, the Department will make payments from the client's monthly grant directly to landlords, utility companies, and grocery stores.

4. Clothing Allowance \$19.8M

The Department proposes to provide \$125 to each dependent child on the caseload in September to cover the costs of meeting winter clothing needs. The legislature has authorized a clothing allowance of \$50 in FY82, \$75 in FY83, and \$125 in FY83, FY84, and FY85.

5. \$50 Child Support Disregard \$7.5M

In accordance with federal regulations, the Department currently requires AFDC recipients to sign over child support payment rights to the Department so that it may establish court orders and collect regularly on their behalf. Under the Deficit Reduction Act of 1984, the Department is required to return the first \$50 of child support collected in a month on behalf of a recipient directly to the recipient, without instituting any offset to the family's grant. Up to 18,500 families will receive the \$50 child support disregard each month in FY86.

6. Supplemental Benefits \$0.7M

Supplemental benefits are state-funded payments which compensate recipients who experience a sudden decline in income for the delay in reflecting this loss through an increase in the grant. The delay results from the retrospective budgeting system required by the federal government for all clients with earnings. Because this reporting process bases grants on income reported in a previous month, without supplemental benefits, a family whose income dropped would have to wait two months to receive an increase in its monthly AFDC benefit.

7. Family Reunification Benefits \$0.5M

Under this program, families eligible for AFDC whose children are temporarily placed in the care of the Department of Social Services may continue to receive AFDC for up to 6 months after the child is temporarily removed, and for the 3 months prior to the return of the child to the home. This grant is intended to enable these families to maintain a household in preparation for the return of their children.

8. Refunds (\$2.4M)

Refunds are checks that are returned because the client has moved or cannot be located.

9. Legal Fees

\$0.1M

In certain instances, the Department is required to pay the legal fees of clients who successfully sue the Department.

10. 10% Payment Standard Increase

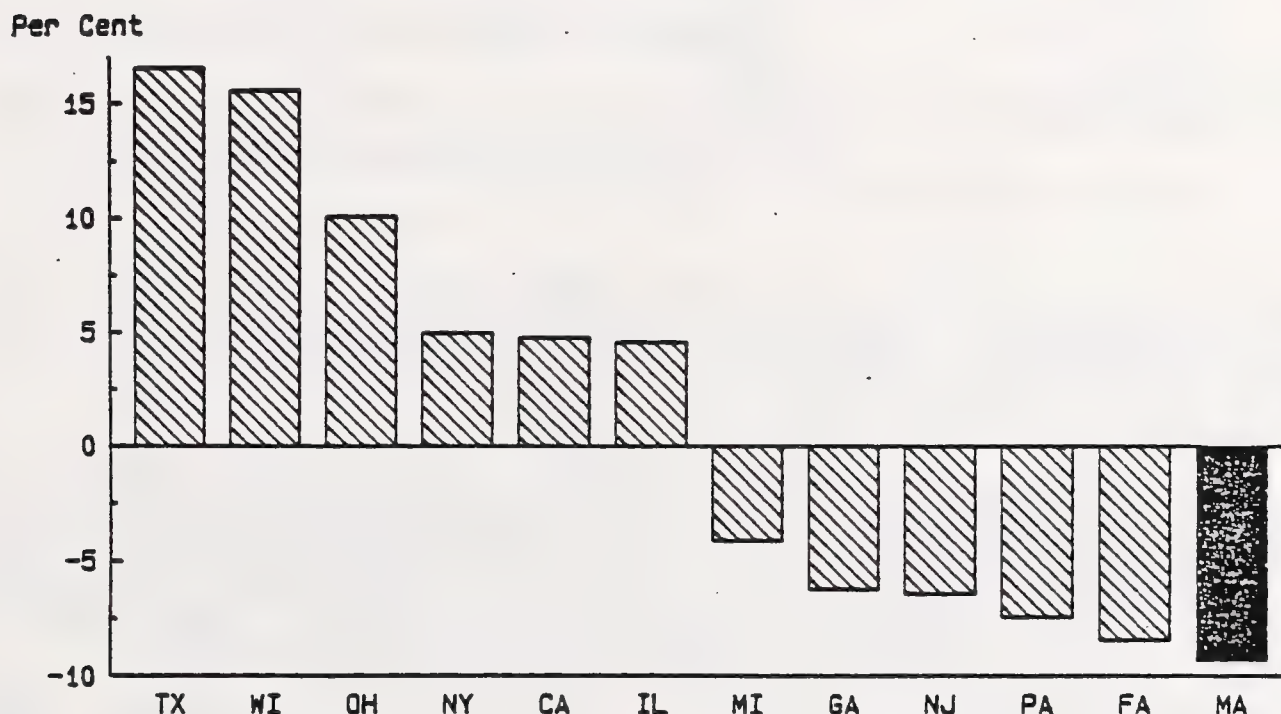
\$44.9M

In order to improve the adequacy of AFDC grants, the Department is requesting a 10% increase in the payment standard, effective July 1, 1986. This increase would increase the maximum monthly payment to an AFDC family of 3 from \$432 to \$476. An estimated 88% of all cases receive the maximum AFDC grant because they have no other source of income; thus 88% of all cases would derive the complete benefit from the 10% payment standard increase. This item also includes funding for an increase in the standard of need, to accommodate the federal requirement that the need standard not fall below the payment standard.

**SPECIAL REPORT ON
AFDC CASELOAD TRENDS
1983-1986**

From January 1983 to July 1985, while the average caseload change among the largest welfare states in the country was an increase of 2.5%, the AFDC caseload in Massachusetts decreased by almost 10%. What happened in Massachusetts was a combination of a growing economy and the Employment and Training CHOICES Program (ET), which has placed over 23,000 welfare clients into full or part-time jobs in the past 2-1/2 years. These placements have saved the Commonwealth an estimated \$69 million after subtracting program costs. The effect of ET is clearly shown in the following chart which compares AFDC caseload changes nationally. As shown, the decline in the Massachusetts AFDC caseload from January 1983 to July 1985 was more than that of any of the top twelve welfare states.

**AFDC Caseload Change
Top 12 Caseload States
January 1983 to July 1985**



During the same period of time that the Massachusetts caseload declined, the unemployment rate dropped in all the 12 states shown. In fact, in 5 of these 12 states the unemployment rate dropped more than in Massachusetts, yet the respective AFDC caseloads did not decrease nearly as much as in Massachusetts.

Twelve Largest Welfare States
AFDC Caseload and Unemployment Trends
January, 1983 to July, 1985

<u>State</u>	<u>AFDC Caseload Change</u>	<u>Unemployment Rate Change (percentage points)</u>
Texas	16.6%	-0.8
Wisconsin	15.6%	-6.8
Ohio	10.1%	-5.6
New York	5.0%	-3.5
California	4.8%	-4.0
Illinois	4.6%	-4.6
Michigan	-4.2%	-6.2
Georgia	-6.3%	-1.0
New Jersey	-6.5%	-3.0
Pennsylvania	-7.5%	-7.1
Florida	-8.5%	-3.4
Massachusetts	-9.4%	-4.4

Clearly, ET would not be the success that it is today were it not for the strong Massachusetts economy; however, having a healthy economy is, in and of itself, not sufficient to effect a large decrease in AFDC rolls, as the preceding chart shows.

A number of factors influence the level of the AFDC caseload. The strength of the Massachusetts economy, the ET program, and a reduction in the error rate have all contributed to reducing the AFDC caseload. On the other hand, an increase in births to unwed mothers and the general increase in the number of single-parent families have combined to increase the pool of families potentially eligible for AFDC.

This special report examines AFDC caseload trends during 1983, 1984, and 1985, detailing the factors influencing different portions of the caseload, and the underlying social and demographic changes which influence caseload levels.

CASELOAD, JANUARY 1983 TO JULY 1985

As noted above, between January 1983 and July 1985, the AFDC caseload declined by nearly 10%. As a result, the AFDC caseload average during FY85 was at the lowest level in 12 years.

<u>Fiscal Year</u>	<u>AFDC Average Caseload</u>
FY73	83,952
FY74	91,738
FY75	106,124
FY76	111,932
FY77	117,592
FY78	121,523
FY79	122,254
FY80	122,003
FY81	122,693
FY82	109,553
FY83	91,355
FY84	87,533
FY85	84,391

Factors Associated With Caseload Decrease

The dramatic AFDC caseload decline in Massachusetts since January 1983 is largely the result of the following factors:

- o A Strong Economy

In the last three years the Massachusetts economy has boomed, with unemployment averaging 3.9% in 1985, the lowest rate of any major industrial state. Further, the unemployment rate for blacks in Massachusetts during 1985 was only 5.3%, one-third of the national black unemployment rate, and less than the total U.S. unemployment rate of 7.2%. This economic vitality has unquestionably helped to reduce the AFDC caseload by making more employment opportunities available to potential welfare clients. However, as past experience shows, a strong economy alone is not sufficient to ensure that welfare recipients find employment. In point of fact, whereas unemployment declined by 50% -- from 11.2% in 1975 to 5.6% in 1980 -- the AFDC caseload actually increased by 12% in that 6 year period. As we have learned from ET, AFDC recipients face many barriers which hinder them in obtaining employment -- barriers such as inadequate education and training, or the lack of child care.

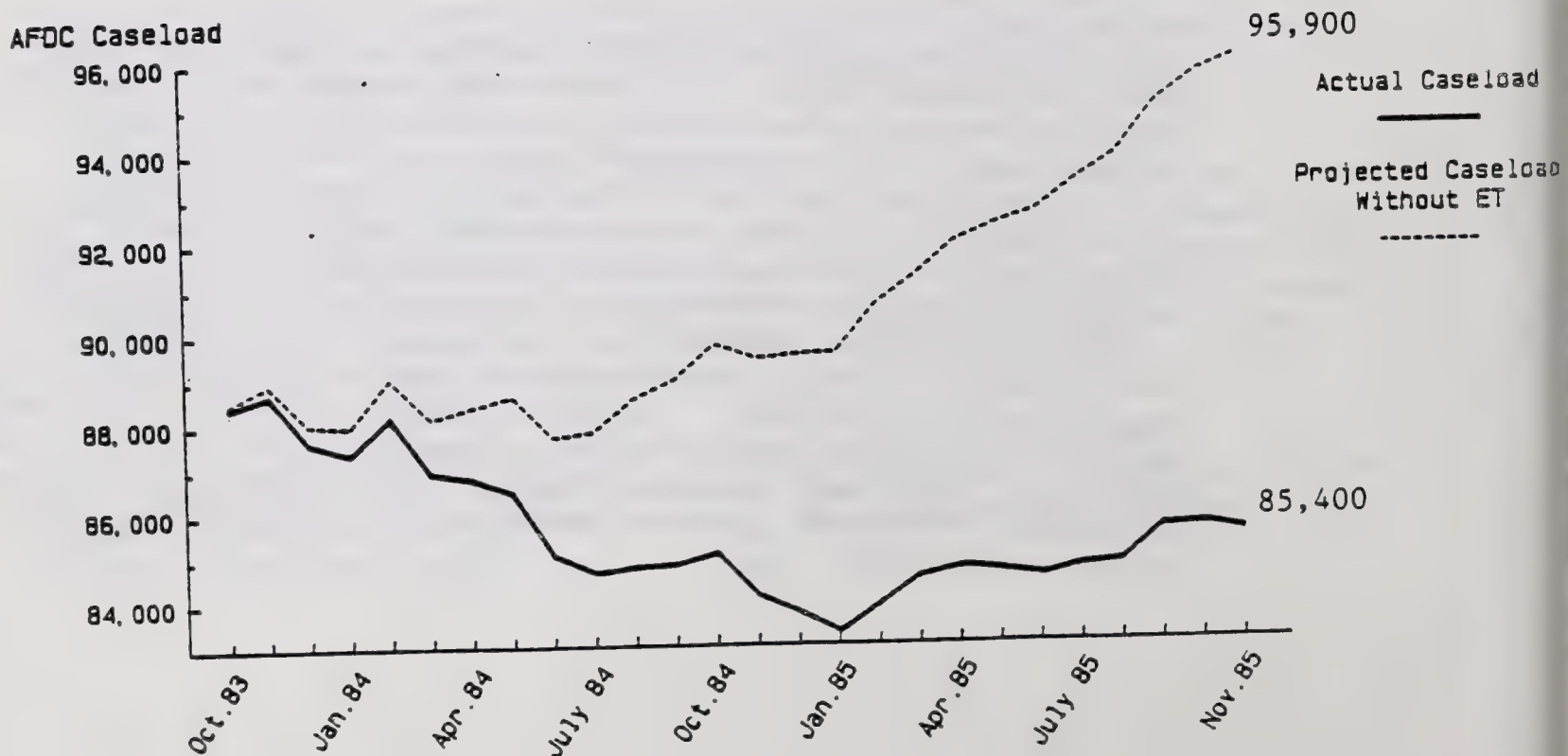
o Employment and Training

The Department's ET CHOICES program is designed to access economic opportunity for welfare recipients by eliminating those barriers which prevent them from obtaining employment. Since its inception in October 1983, ET has:

- placed over 23,000 recipients or applicants into full or part-time jobs,
- saved the Commonwealth an estimated \$69 million in benefit payments after subtracting program costs,
- provided full-time ET job-holders with average starting wages of more than \$10,000 per year -- twice as high as average welfare benefits and 11% above the federal poverty level,
- resulted in a substantial reduction in long-term welfare dependency as evidenced by the fact that 86% of ET participants who left the caseload were still off welfare one year later.

The AFDC caseload is significantly lower today than what it would have been without ET. The Department's data, based on computer matching of ET placements and actual case closings, show that the AFDC caseload in November 1985 would have been nearly 96,000 compared to 85,400 were it not for ET.

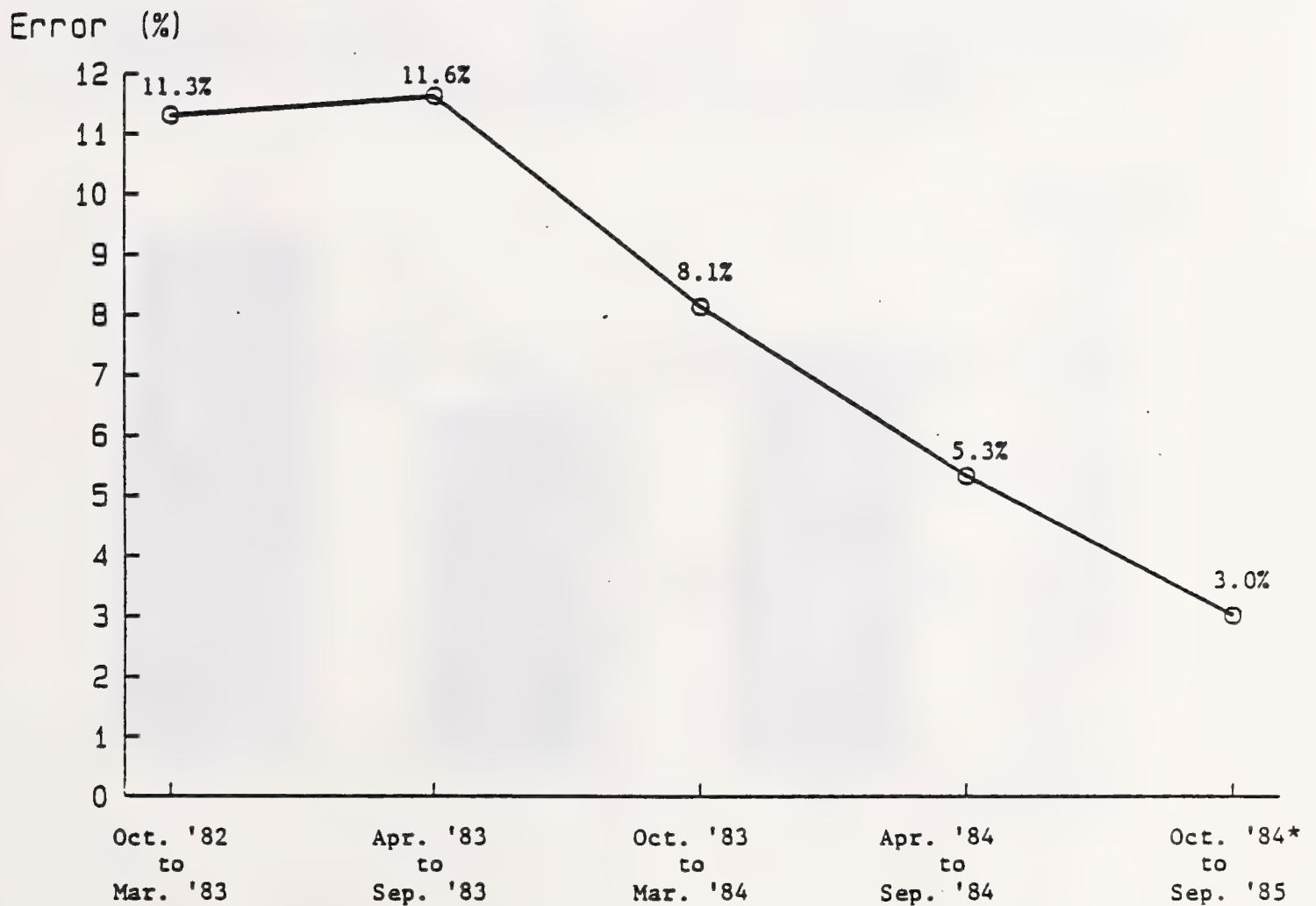
**EFFECT OF ET
ON THE AFDC CASELOAD**



o Reductions in the Error Rate

The Dukakis administration has placed a high priority on improving payment accuracy and has reduced the AFDC error rate from almost 12% in early 1983 to 3% in 1985, the lowest rate in the history of the Department. These efforts to reduce the AFDC error rate have also reduced the AFDC caseload by eliminating cases from the caseload who were not eligible for assistance.

AFDC Error Rate 1982 to 1985



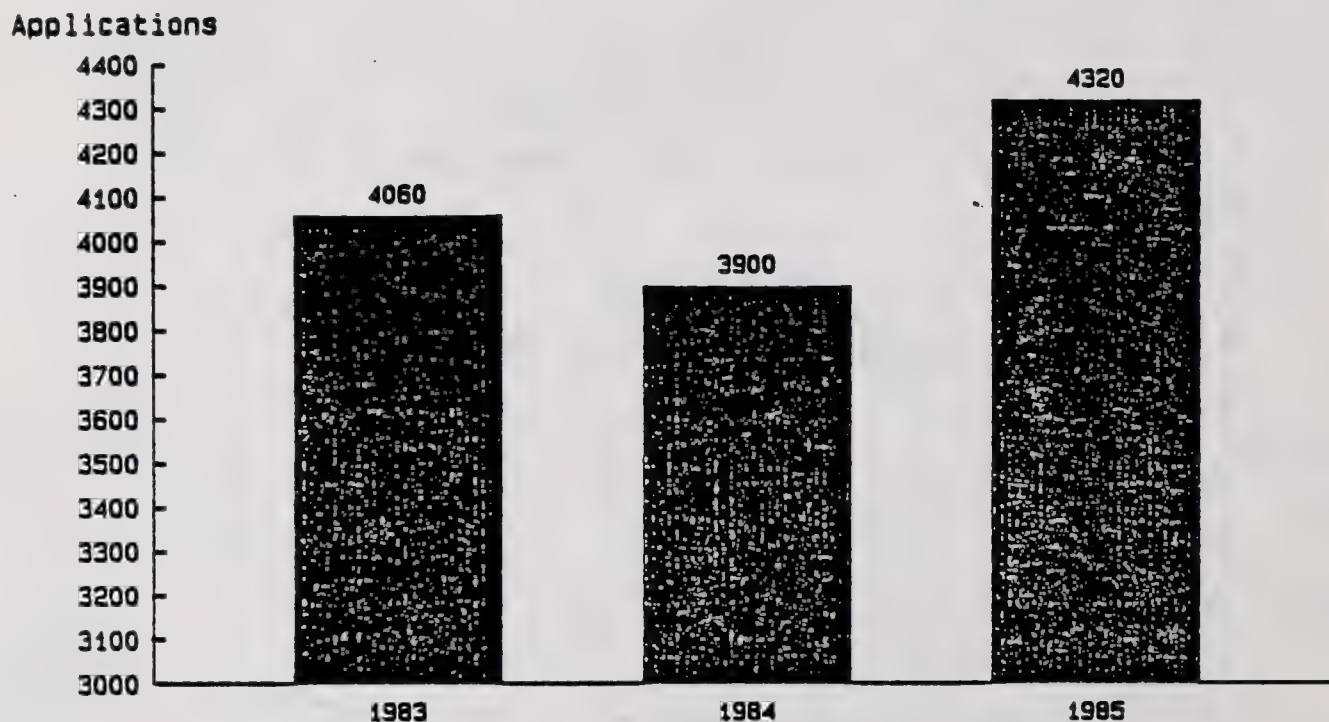
* Error rate sampling conducted on a yearly basis beginning 10/84.

RECENT CASELOAD TRENDS: 1985

In January 1985 the AFDC caseload reached a twelve year low of 83,280 cases. From January to October 1985 the AFDC caseload rose, and then declined in November and December. The December caseload of 85,210 is 2% higher than the low point in January 1985.

One of the major forces influencing the recent caseload increase is the marked increase in applications for assistance. As shown below, the average number of AFDC applications received each month increased by 11% in 1985. This increase in requests for assistance is, in large part, responsible for the recent caseload increase.

**Average Monthly AFDC Applications Received
1983 - 1985**

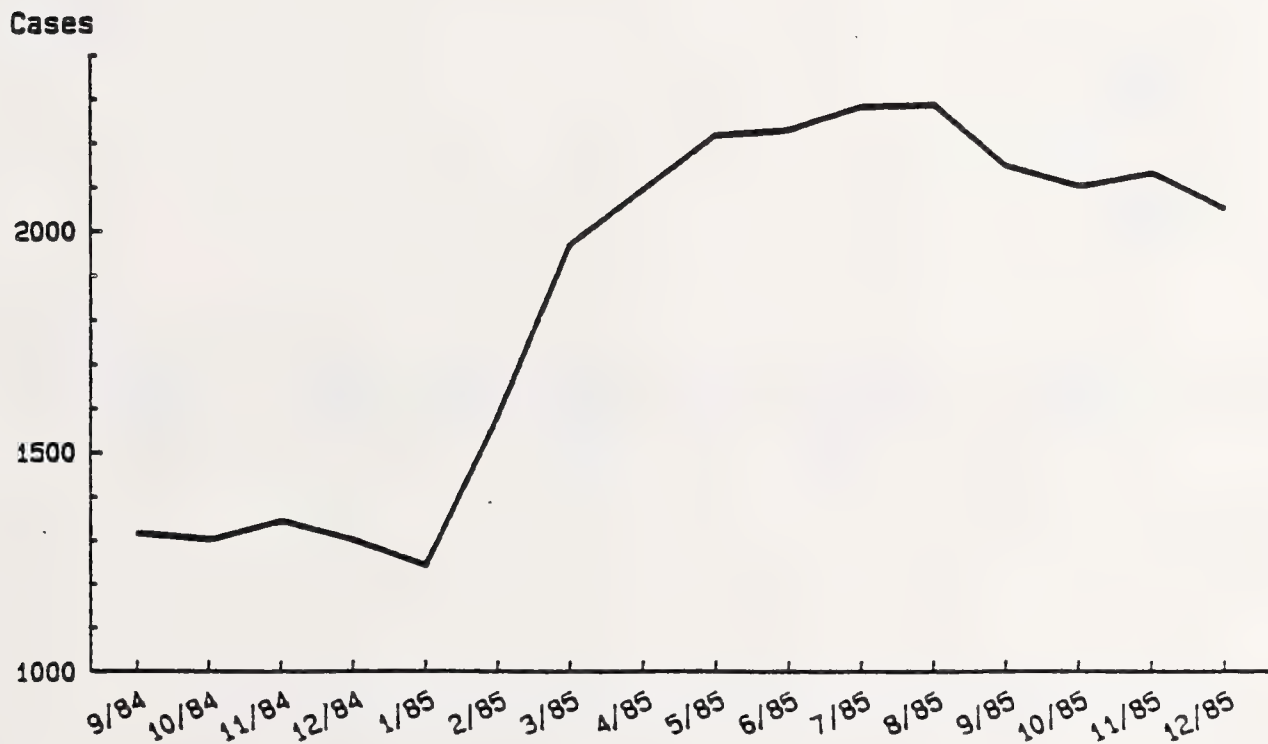


In many respects the increase in applications and the subsequent caseload increase during 1985 is not unusual -- it results from a change in eligibility policy, and seasonal fluctuations. The AFDC caseload consists of three components: pregnant women, unemployed parent cases, and single-parent families. The relation between changes in each of these components and the recent caseload increase is explained below.

Pregnant Women

One component of the AFDC caseload is pregnant women with no other dependents. The pregnant women caseload has nearly doubled over the past year as a result of new legislation which became effective in January 1985. This legislation, (Ch. 398 of the Acts of 1984), extended eligibility for AFDC to pregnant women who are in their first or second trimester of pregnancy and who have no other dependents. This benefit was eliminated by the Reagan Administration in 1981 as part of the Omnibus Budget Reconciliation Act. Since the state legislature re-established this benefit in January 1985, the number of pregnant women on the caseload has increased by about 1,000 -- accounting over 80% of the AFDC caseload increase from January to June 1985, despite the fact that pregnant women make up only 2% of all AFDC cases.

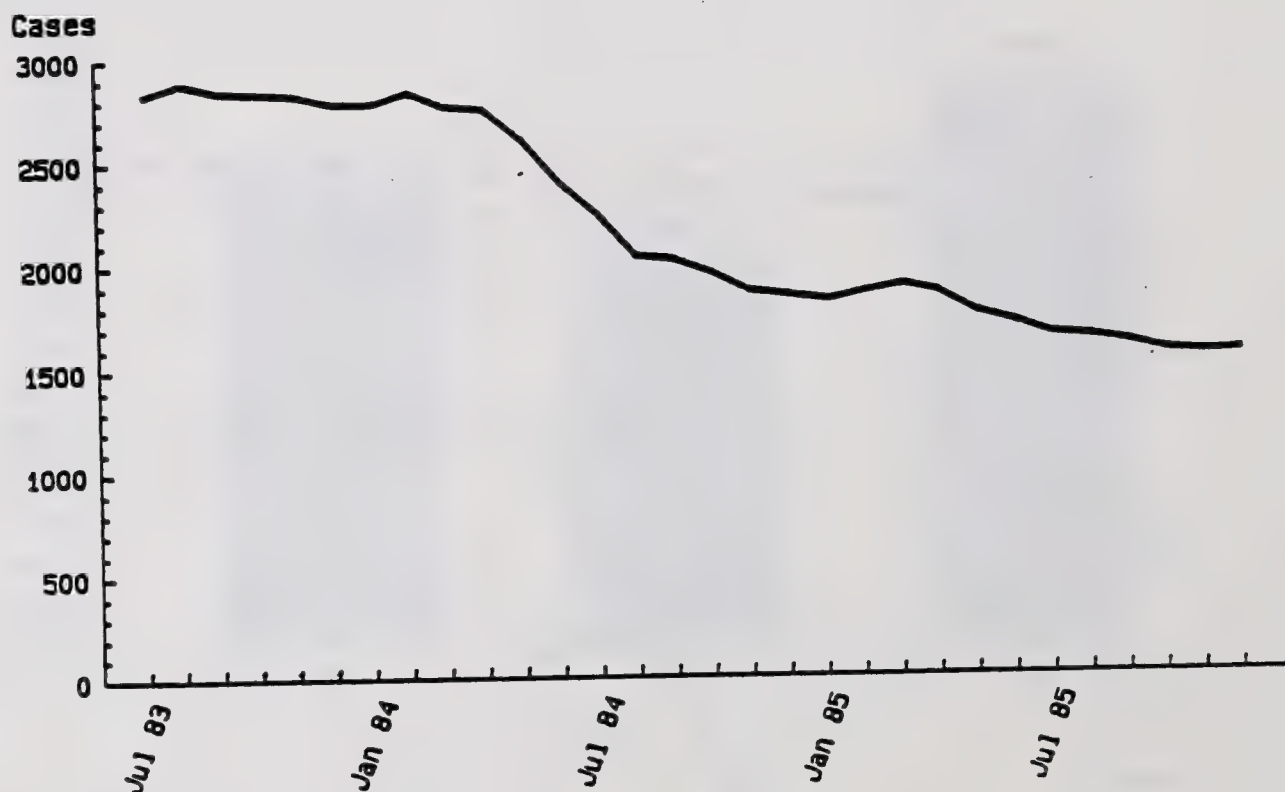
Pregnant Women With No Other Dependents
9/84 to Present



Unemployed Parent Caseload

The Unemployed Parent (UP) component of the AFDC caseload consists of two-parent families in which the principal earner is unemployed. As shown below, the UP caseload has declined by nearly 50% since October 1983. Even during 1985, when the overall caseload increased, the UP caseload declined by over 1,200 cases. This continued decline in the UP caseload is largely the result of the Employment and Training Program, as well as the strong Massachusetts economy. Because UP cases are often headed by men with recent employment histories, these families have been particularly likely to benefit from the ET program. As indicated in the following diagram, within five months of implementation of ET in October 1983, the UP caseload dramatically declined, continued to decline since then. Unemployed Parent cases now make up only 2% of the AFDC caseload.

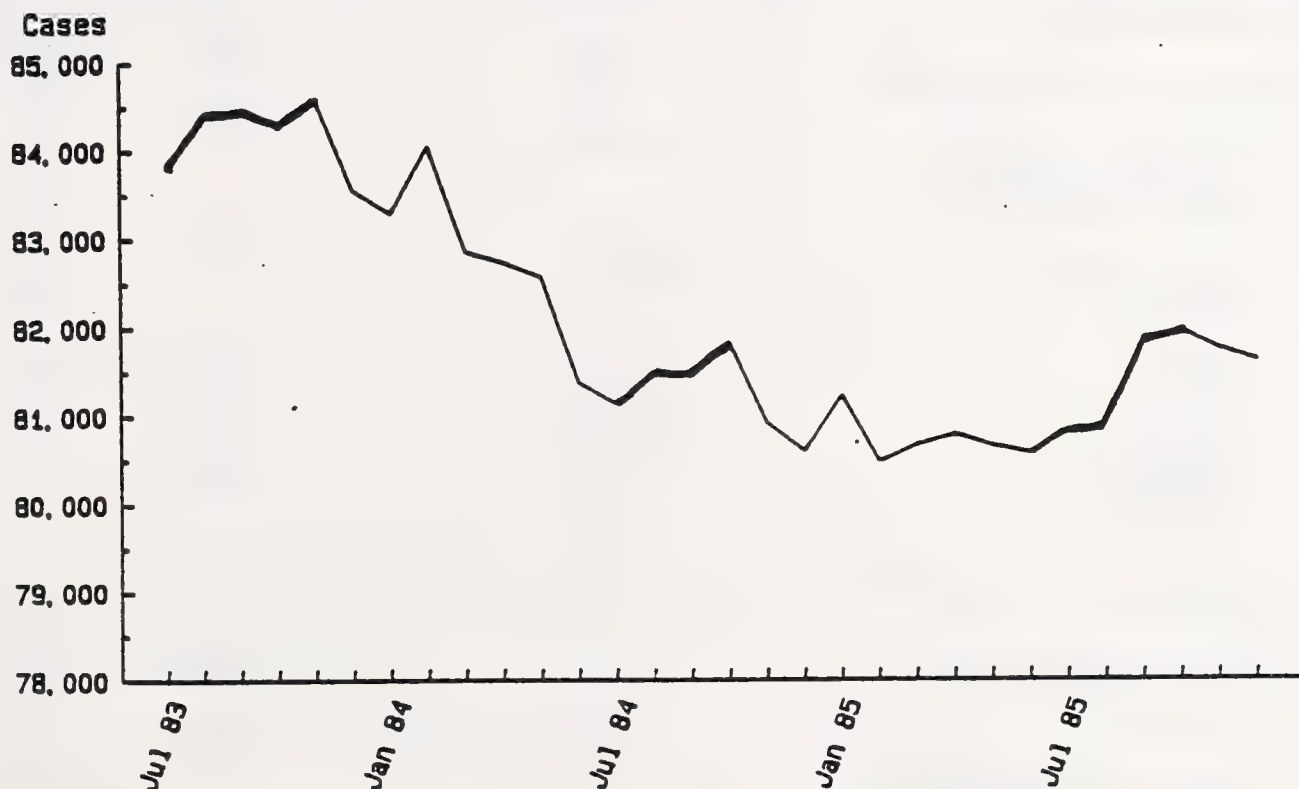
Unemployed Parent Caseload
FY84 - FY86



Single-Parent Families

By far the largest component of the AFDC caseload (96%) consists of single-parent families. As shown below, this component of the caseload is strongly influenced by seasonal factors. In each of the years from FY84 to FY86, the AFDC caseload has increased from July to October, and declined in November and December. One explanation for the increase in the caseload during the summer is that low income single parents are less likely to work and more likely to be on the caseload when their children are not in school. The November and December declines are related to an expansion in employment opportunities during the pre-Christmas season. Thus the FY86 caseload increase from July to October, and caseload decline in November and December are partially explained by seasonal fluctuations.

AFDC Single-Parent Families With Children
FY84 - FY86



CHARACTERISTICS OF NEW ENTRANTS

As indicated below, new families entering the AFDC caseload in FY86 are not significantly different from those entering in FY84. There were some small differences, however, which reflect gradual shifts in the composition of the caseload. New entrants in FY86 were less likely to be unemployed, male, white, or to have earnings than those in FY84. In addition, those entering in FY86 were slightly younger and had smaller families than those entering in FY84. The characteristics of those entering in FY86 would tend to make them somewhat harder to serve in terms of job placement.

Characteristics of AFDC Recipients (Heads of Household)

	<u>Entrants</u> <u>7-10/83</u>	<u>Entrants</u> <u>7-10/85</u>
Total Number	15,877	16,761
Percent with Earnings	13.3%	9.7%
Percent Unemployed Parent cases	9.9%	6.5%
Percent Male	12.0%	8.1%
Race		
White	68.2%	64.7%
Black	14.8%	17.7%
Hispanic	15.9%	15.9%
Other	1.1%	1.7%
Recipient's Age (Avg.)	24.0	23.7
Recipients under Age 19	11.4%	12.5%
Number of Dependents	1.6	1.5

Age of Entrants

As shown above, teen parents represent a relatively small proportion of parents entering the AFDC caseload. Only 12.5% of entrants were under age 19 in 1985, slightly above the 1983 level of 11.4%. The recent caseload increase is not principally the result of an influx of teenage parents. However, as explained on the following pages, a substantial portion of welfare dependence is related to teen pregnancy. Over half of all current AFDC female single parents under age 35 were under age 19 at the birth of their first child.

Decline in Cases with Earnings

The proportion of new AFDC cases with earnings has declined from 13.3% in FY84 to 9.7% in FY86. This decline in earners on the caseload is likely the result of the ET Program and the strong Massachusetts economy. By expanding the employment potential of AFDC clients, the ET Program has helped a greater proportion of clients who want to work to earn enough income to leave the AFDC caseload altogether.

Unemployed Parent Caseload Decline

As noted above, the percentage of entering households who are intact two-parent unemployed families declined from 9.9% in FY84 to 6.5% in FY86. This is consistent with the long-term decline in the Unemployed Parent caseload.

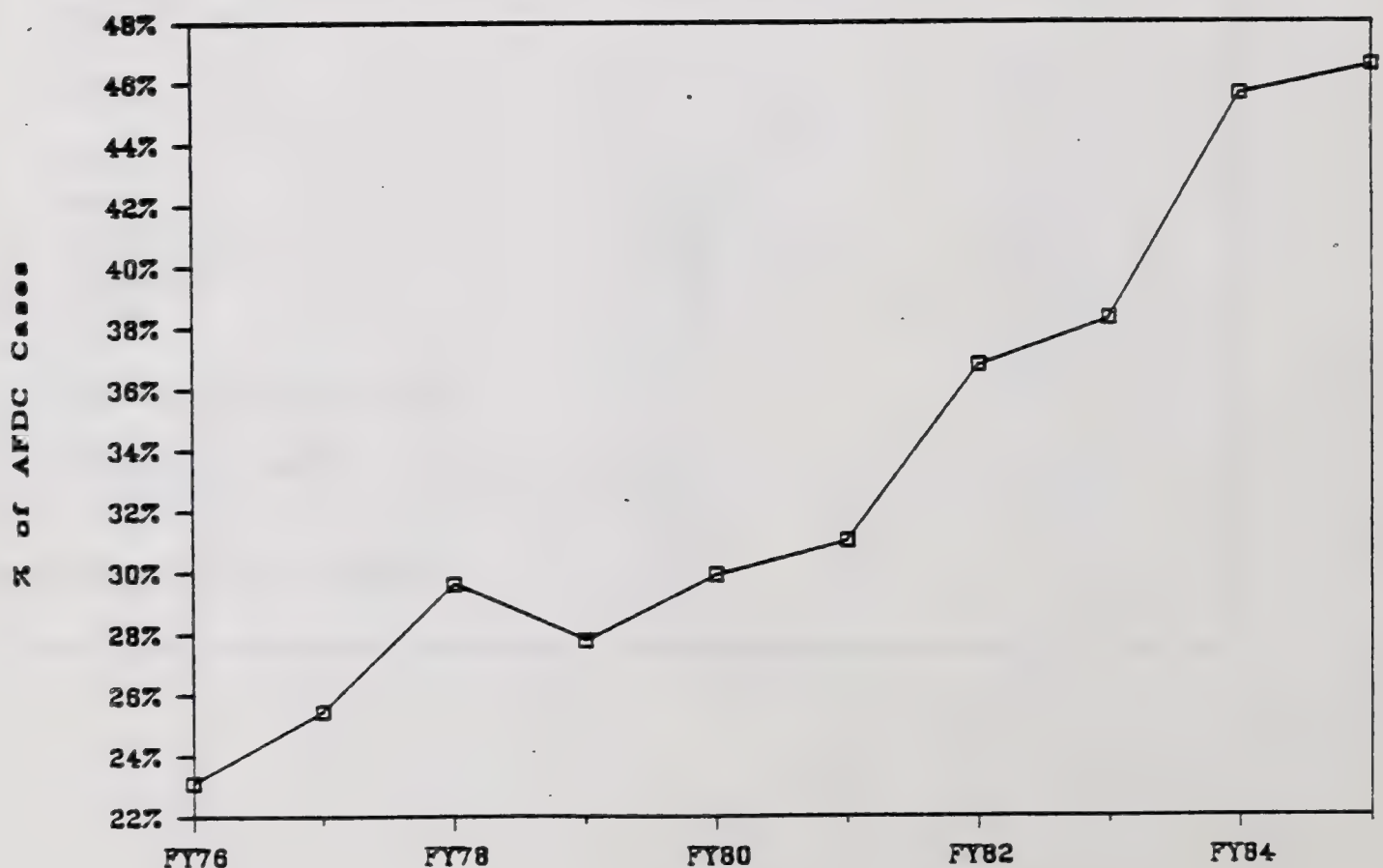
LONG TERM CHANGES IN FAMILY FORMATION

While the characteristics of AFDC entrants have not markedly changed over the past two years, there have been more gradual shifts in the composition of the AFDC population. Over the past decade the composition of families on the AFDC caseload changed dramatically, reflecting underlying shifts throughout the Commonwealth in the pattern of family formation. These underlying forces may have contributed to the recent increase in the AFDC caseload and mean that those clients on the caseload may be harder to place into jobs than were former clients already placed into jobs.

Increase in Unmarried AFDC Parents

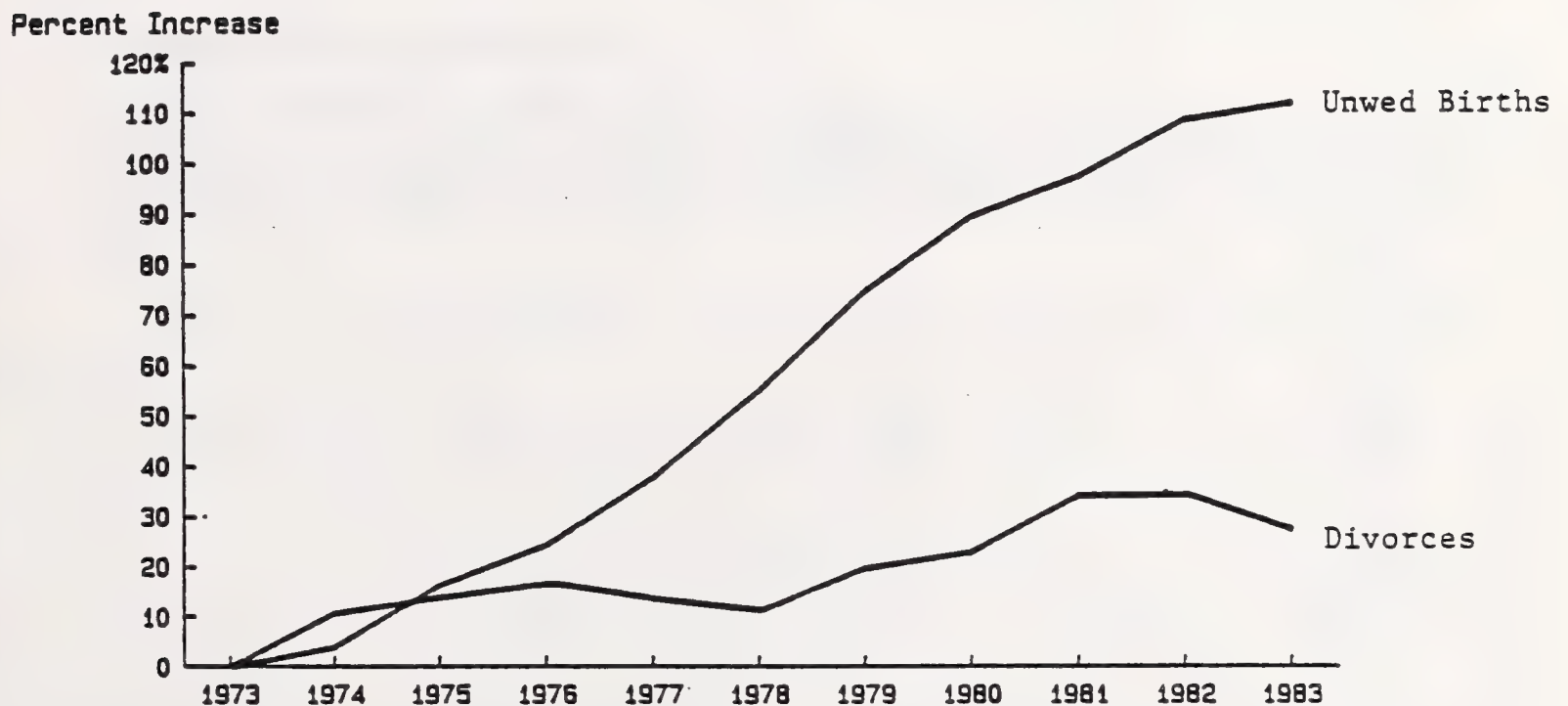
One of the most dramatic shifts in the composition of the AFDC caseload is the increase in the proportion of AFDC parents who have never been married. In 1975, only a minority of AFDC single-parent families had never married (23%). By 1985, half of all AFDC single-parent families had never married. AFDC dependency is more and more the product of births to unmarried women and the lack of family formation, rather than the result of marital dissolution.

Percent of AFDC Cases With a
Parent Who Has Never Married



The recent changes in the composition of the AFDC caseload reflect demographic shifts throughout the Commonwealth. Between 1973 and 1983, the number of births to unwed parents increased 110% -- four times the rate of increase in divorces. In 1983, the Massachusetts divorce rate decreased from 3.4 per 1000 in 1982 to 3.2 per 1000 in 1983. Indeed, in 1983, the Massachusetts divorce rate was the lowest in the country. Given these trends, it is not surprising that the number of AFDC parents who had never married increased by 14,000 from FY75 to FY85 and the number of divorced or separated AFDC parents declined by 24,000.

**Increase in MA Divorces
V. Increase in Unwed Births
1973 - 1983**

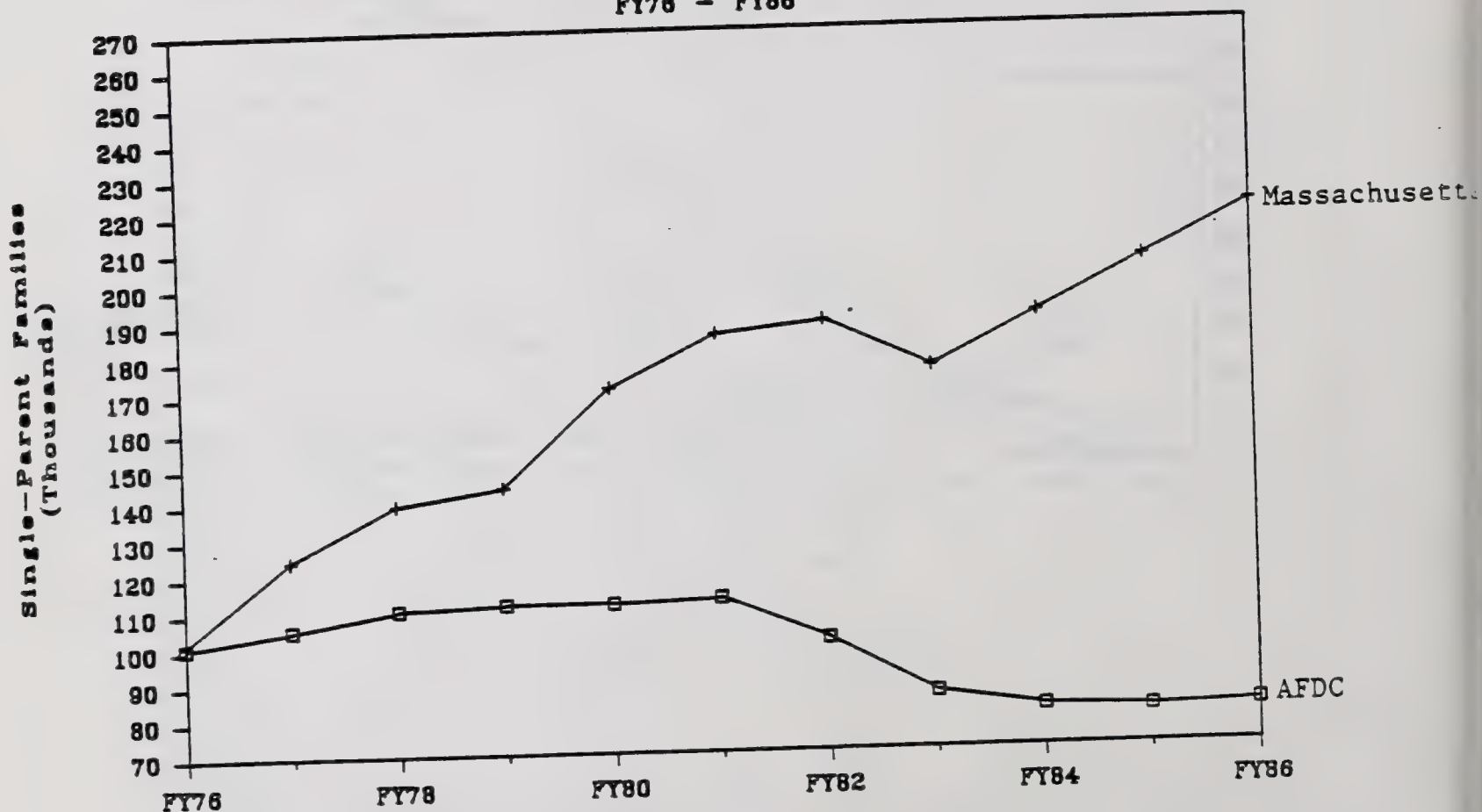


Growth in Potentially Eligible Population

There are an estimated 220,000 single-parent families in Massachusetts. Of these families, only a minority (less than 40%) are currently on the AFDC caseload. While many of these families are not currently poor, they are at higher than average risk of slipping into poverty. Single parent families are among the most economically vulnerable segments of the Commonwealth, with poverty rates four times that of other families. The economic welfare of this population is particularly important in determining the AFDC caseload.

As shown below, single-parent families have increased dramatically over the past decade. This increasing number of single-parent families continually exerts upward pressure on AFDC caseload, and may be related to the recent caseload increase. Given the marked increase in potentially eligible families, it is remarkable that the AFDC caseload has remained relatively stable. The caseload decline in FY82 and FY83 was primarily the result of the Omnibus Reconciliation Act of 1981, which markedly reduced the caseload by restricting eligibility for AFDC. Since then, both the expanding economy and the ET programs have contributed to further caseload reductions.

Number of Single-Parent Families
FY76 - FY86



Implications of Shift Towards Unmarried Births

One of the most unfortunate consequences of the growing proportion of births to unwed parents is the number of Massachusetts children in poverty. Over 19% of all children born in Massachusetts during 1984 had spent some time on the welfare caseload by November 1985, and 17% had received AFDC. These preliminary statistics, which were culled from the Department's computer files, are roughly consistent with what we know about the poverty rates of Massachusetts children. According to the March 1984 Current Population Survey, 14% of all children under 19 were poor in 1983.

When a single-parent family is headed by a young parent, the incidence of poverty is particularly severe. 29% of all children born in 1984 to a mother under age 19, and 28% of children born to mother between 20 and 24 had been on the AFDC caseload by November 1985. Moreover, there is a relationship between teen pregnancy and persistent welfare dependency. Of all AFDC single female parents under age 35, approximately 50% gave birth to their first child while under age 19. By contrast, of all Massachusetts first-time mothers under age 35 in 1984, only 17% were under age 19.

Further Efforts to Manage the Caseload

During the first year of the ET program, as ET participants went into training and education programs, the Department placed into jobs clients who were relatively more likely to be job ready or have an easier time finding a job.

- 37% of all ET placements were men, as opposed to 6% of all AFDC recipients. Many of these men had previous job experience.
- 74% of all ET placements had a high school degree, while only 50% of AFDC recipients graduated from high school.
- 76% of ET placement were white, as opposed to 64% of AFDC recipients.
- 44% of ET placements had children under age 6 as opposed to 65% of AFDC recipients.

Given both an increased demand for AFDC, and the change in the composition of the AFDC population towards the harder-to-serve, the Department will redouble its efforts this year and next to help AFDC clients move out of poverty to economic self-sufficiency. The Department's efforts in FY86 and its proposed initiatives in FY87 will be critical in order to continue to extend economic opportunity to AFDC families. Key elements of the FY86 agenda include:

- o Increased Emphasis on High Wages

To help more clients to break out of poverty, in FY86 the Department is placing a high priority on obtaining adequate wages for ET placements. In its contracts with ET service vendors, the Department is rewarding contractors for the wage level of placements as well as for the total number of clients placed.

- o Expansions to Target Special Populations

In FY86, the Department will be offering a special employment program to serve teenage parents and dependents on AFDC. In addition, the Department will also offer a special program targeted towards minorities, to begin to address the problems which have historically kept minorities behind whites in the labor market.

- o Transitional Employment Assistance

In order to help clients successfully deal with the transition from welfare to employment, the Department will provide counseling and guidance services to AFDC clients who are placed into full-time jobs. This program will help clients to remain off the caseload once they are placed into jobs, and thus result in more permanent improvements in their economic status.

In FY87, the Department proposes to strengthen ET through the following new initiatives:

- o ET Health Choices

One of the barriers to employment for AFDC clients, most of whom are women with young children, can be the lack of adequate health insurance in the jobs available to them. For FY87, the Department is proposing to offer medical coverage for up to a year after placement to ET placements who do not receive medical coverage through their employers. This prevent mothers from having to choose between Medicaid for their children or work.

- o Expanded Education and Adult Literacy Training

Many of the harder to serve AFDC families need literacy and basic education in order to find a worthwhile job. Because these families generally have more educational deficiencies than those served in the past, they will require more training in order to obtain employment. To extend economic opportunity to most disadvantaged AFDC families, the Department is proposing to expand significantly its adult literacy and education programs in FY87.

GENERAL RELIEF (4406-2000)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures/ Appropriation	\$70,306,895*	\$62,806,138*	\$83,407,165**	\$83,193,675
Caseload	27,931	26,305	24,869	25,627

General Relief (GR) is an entirely state-funded program that provides cash assistance to needy individuals and families who are ineligible for other cash assistance programs. GR recipients are among the neediest men and women in the Commonwealth. Recipients must meet income guidelines and must meet one of eight non-employability criteria. Almost 60% are unable to work due to a physical or mental disability, and approximately 700 are homeless. Certain low-income families who are ineligible for AFDC may receive GR if they meet GR income and asset guidelines.

In addition to cash grants, the GR account funds Emergency Assistance services to prevent or respond to homelessness, assistance to recipients who apply for SSI, payments to recipients who reside in rest homes and halfway houses, and a \$90 clothing allowance for each individual on the caseload in September. The Department funds medical services for GR recipients through the GR Health Services account (4406-5000), and GR Employment and Training services through the GR ET account (4407-1010).

FY84 - FY86 PERFORMANCE

Between FY84 and FY86, the administration, the legislature, and the Department have significantly improved the GR program. Initiatives have included expanded eligibility to serve needy populations, increased benefits and essential services, and opportunities for recipients to move out of poverty through rehabilitation, employment, or conversion to the SSI program through a new GR Choices program.

A. Expanded Services to Needy Populations

As the GR program serves individuals who are ineligible for other cash assistance programs, GR eligibility criteria have expanded in response to restrictive federal policy changes in the AFDC and SSI programs. Some of the Commonwealth's initiatives include:

* Net of GR Health Services.

** Appropriation.

- o Extending eligibility to the homeless

In October 1983, the legislature passed Chapter 450 of the Acts of 1983, "An Act to Prevent Homelessness". One of the provisions of this legislation eliminated the permanent residency requirement for General Relief, making cash assistance available for the first time to homeless men and women. The Department currently provides GR grants to approximately 700 homeless people.

- o Providing benefits to over 2,000 households who lost their AFDC benefits

When Congress passed the Omnibus Budget Reconciliation Act of 1981 (OBRA), women whose youngest children were between the ages of 18 and 21 lost their AFDC benefits. With few other sources of assistance available, over 2,000 such households become eligible for GR benefits, most because they were headed by parents who were age 45 or over and lacked a work history.

- o Providing benefits to former SSI recipients

Between 1980 and 1983, approximately 7,000 SSI and Social Security Disability Insurance (SSDI) recipients in Massachusetts lost their benefits when the Reagan administration increased the frequency of medical reviews of disability cases. Many of these individuals were eligible for GR benefits, which are almost 50% lower than the partially federally-funded SSI grants.

Massachusetts and 32 other states initiated court actions to block these restrictive reviews, and the federal government ordered a moratorium on the reviews in 1984. Approximately 60% of the terminations were reversed upon appeal.

The Department is currently funding the GR Choices program to assist disabled GR recipients, including former SSI and SSDI recipients, in appealing or applying for SSI benefits.

- o Providing GR Emergency Assistance to prevent homelessness

In the two years since passage of Chapter 450, the Department has greatly expanded the services available to the homeless. GR Emergency Assistance services, established in January 1985, provide a variety of services to prevent or eliminate homelessness. Through GR Emergency Assistance, and a smaller Residence Acquisition Program established in December 1983, the Department has enabled almost 2,000 households to establish permanent housing or to pay rent arrearages.

In addition, the Department has established a variety of services funded in other accounts to serve this vulnerable population. These include \$697,000 for homeless health and outreach and advocacy grants funded from the GR Health

Services account (4406-5000) to assist homeless individuals in applying for public assistance and medical benefits, and \$1.1 million for housing search and homelessness prevention services funded from the Homeless Services account (4406-3000).

B. Increased Benefits

o Cost-of-Living Increases

A 9% FY86 cost-of-living (CoL) increase, a 4% FY85 cost-of-living increase, and a major FY83 grant consolidation have raised GR payment standards 30% in two and a half years. In May 1983, thirteen separate payment standards and special payments were consolidated into four standards, raising average grants and simplifying benefit calculations. This was followed by a 4% CoL increase in FY85, and a 9% CoL in FY86.

While this cumulative increase has kept benefits ahead of inflation, which increased 13% between FY83 and FY86, the GR payment standard for individuals is currently 13% less than the AFDC payment standard, and 8% less than the AFDC standard for a family of 4. The 10% CoL proposed in FY87 at a cost to the Department of \$7.3 million is an important step in improving the adequacy of GR benefits.

o \$90 Clothing Allowance

In FY84, the Department and the legislature instituted a \$90 GR clothing allowance. The clothing allowance is a one-time payment of \$90 made in September to each recipient. It is a critical supplement to monthly cash payments, especially to the growing number of families on the GR caseload. Clothing allowance expenditures in FY86 totalled \$2.6 million.

C. Opportunities for Self-Sufficiency: GR Choices

Based on the success of the ET Choices program, the Department has established the GR Choices program to provide opportunities for GR recipients to move out of poverty. GR Choices offers three types of services to GR recipients, based on their background, capabilities, and interests:

o GR Employment and Training Opportunities

In FY85 the Legislature granted the Department authority to establish an Employment and Training program for GR recipients. These services are targeted to four categories of GR recipients (family heads, ex-offenders, halfway house residents, and recipients age 45 or over). The program, based on the ET program, emphasizes the services needed by GR recipients, who often have minimal work experience or educational backgrounds. In the first thirteen months of

operation, the GR ET program has placed over 800 recipients into unsubsidized employment. With an average wage of \$5.10 per hour, these placements provide these individuals with a yearly income that is more than three times the average GR grant of \$3,000.

o Vocational rehabilitation services through the Massachusetts Rehabilitation Commission

Recognizing that physically and mentally incapacitated recipients, who comprise almost 60% of the caseload, face severe barriers to self-sufficiency, the Department has established an interagency agreement with the Massachusetts Rehabilitation Commission (MRC).

Through this agreement, funded from the GR and GR Health Services accounts (4406-5000), MRC will conduct vocational and medical assessments of 600 client volunteers, and will develop an individual rehabilitation plan for each. MRC will provide participants with the following services:

- placement in vocational rehabilitation programs, leading to job placements;
- placement in employment and training programs, leading to job placements; or
- assistance with SSI applications, leading to conversion to the SSI program.

In this twelve month interagency agreement, MRC will place 225 disabled clients into rehabilitation programs and employment, and will assist 100 clients in obtaining SSI benefits.

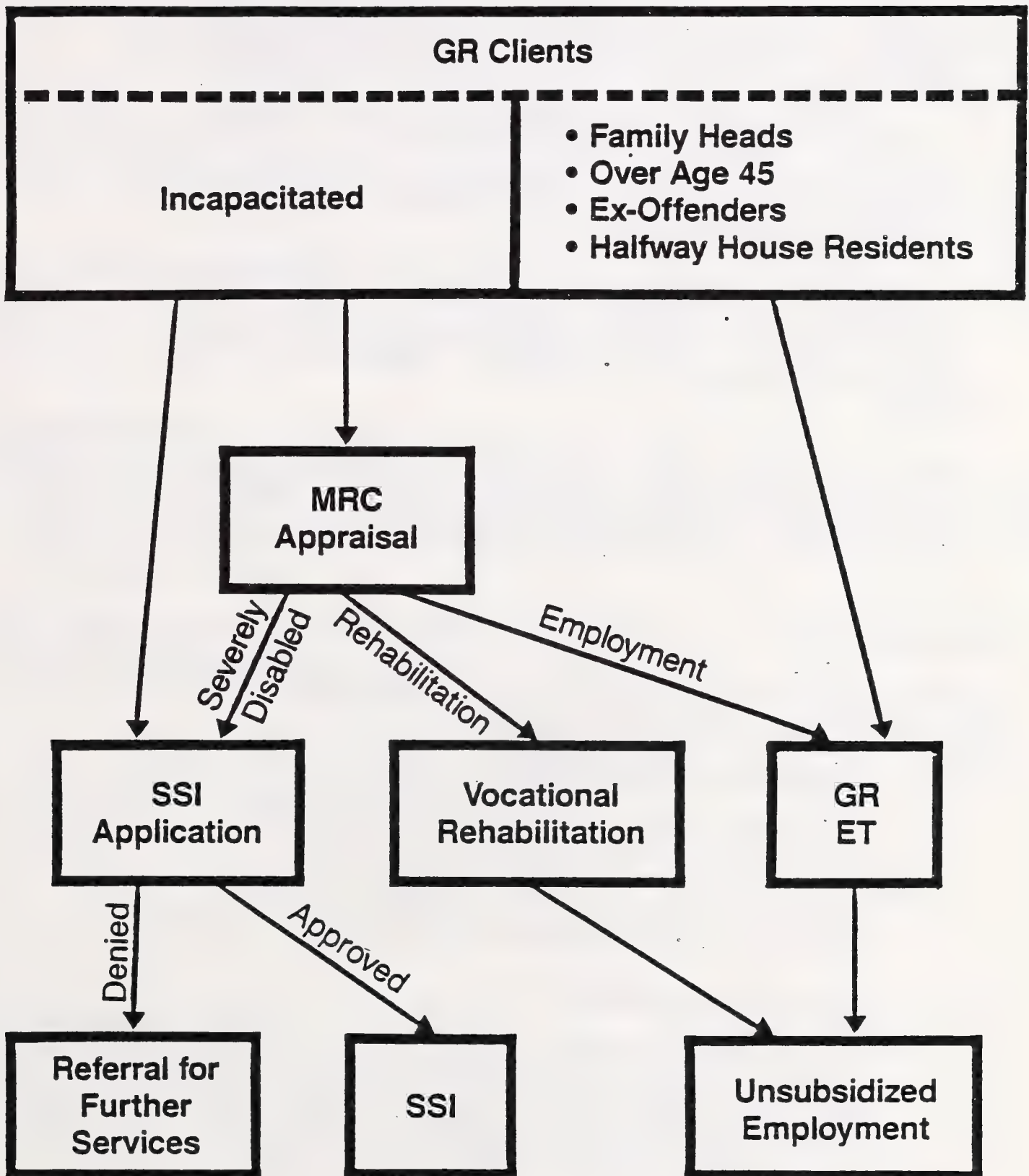
o GR/SSI advocacy services

The Department has contracted with legal service agencies to serve clients who are too severely disabled to benefit from employment or rehabilitation services. These agencies will represent disabled recipients whose applications for SSI have been denied.

These services are critical to the 14,000 incapacitated GR clients because the SSI program offers benefits that are almost twice as high as GR and includes full Medicaid coverage. In addition, SSI cash assistance, which is partially federally funded, has lower costs to the state than the entirely state-funded GR program.

The combination of legal advocacy and MRC services will enable 500 GR clients to be approved for SSI benefits.

GR CHOICES PROGRAM



D. Implemented Policy Changes to Serve Needy Populations and Improve Services

In FY85 and FY86, the Department implemented several policy changes designed to expand eligibility and improve services to needy populations, and to maintain consistency with AFDC policies.

In compliance with the Cumby-Lopez court decision in FY86, the Department removed the age restriction on full-time students in secondary school. This policy change will enable the 700 students currently receiving GR to complete their high school education beyond their nineteenth birthday.

In addition, the Department removed GR citizenship restrictions in compliance with Executive Order 257, issued by the Governor in October 1985. This revision enables the Department to serve eligible, low-income individuals, regardless of their citizenship status.

Other important policy revisions implemented in FY86 include an increase to \$75 in the work-related expense deduction as an incentive to employment, and the clarification and revision of the verifications required to establish GR eligibility.

FY87 INITIATIVES

In FY87, the Department proposes to address the immediate and long-term needs of GR clients with the following initiatives:

o 10% cost-of-living increase

As a further step in raising GR benefits, the Department proposes a 10% increase in the payment standard. The cost of this proposal is estimated at \$7.3 million for the 24,000 non-institutionalized GR recipients projected in FY87. This increase is a critical step in preventing homelessness.

o \$90 clothing allowance

The Department proposes a \$90 one-time clothing allowance to all recipients eligible in September 1986 at a cost of \$2.7 million. This clothing allowance, which was established in FY84, represents a critical supplement to cash grants, particularly to the more than 1,500 families on the caseload.

o Expand GR Choices

The Department will continue to fund the services initiated in FY86 to provide GR clients with opportunities to move out of poverty, including:

- continued GR ET services. These services, which will result in 900 job placements, will be funded through the GR ET account (4407-1010);
- a full year of GR/SSI advocacy services. The Department will fund a full year of services with legal service agencies to represent disabled GR clients through the SSI appeals process. These agencies will also assist recipients who are unable to apply on their own with initial applications for SSI. A full year of services in FY87 may result in over 400 conversions to SSI;
- a full year of MRC services. The Department will renew its interagency agreement with the Massachusetts Rehabilitation Commission to provide vocational and disability assessments, and assistance with SSI applications for disabled GR recipients. In FY87, MRC services will result in 225 job and vocational rehabilitation placements, and 100 conversions to the SSI program.

THE GR PROGRAM

In order to be eligible for GR, applicants must be ineligible for other forms of public assistance and must demonstrate that they meet categorical and financial eligibility requirements. These requirements are described below.

A. Eligibility Requirements and Benefit Levels

o Categorical Eligibility

The principal categorical requirement for GR is nonemployability. An applicant is considered nonemployable if he or she is a member of one of the following groups:

- families*
- physically or mentally incapacitated
- SSI applicants, or persons 45 or over who lack a work history
- halfway house residents
- ex-offenders who have been imprisoned for a minimum of two months.**
- participants in Massachusetts Rehabilitation Commission programs
- full-time students in secondary school
- persons caring for the physically or mentally incapacitated

o Financial Eligibility

If an applicant meets one of the above categorical requirements, he or she must also meet financial eligibility requirements. Both income and assets are considered in determining financial eligibility.

- Assets

The assets of an individual applicant must not exceed \$250, while the assets of an applicant with one or more dependents must not exceed \$500.

- Income

Countable income, which is the applicant's total income minus a \$75 work-related expense deduction if he or she is employed, must be less than the appropriate payment standard. The payment standard depends on the applicant's living arrangement and family size, as described in the following paragraph. If countable income exceeds the payment standard, the applicant is ineligible; if it is below the standard, the difference between countable income and the standard becomes the applicant's grant.

o Living Arrangement

The four living arrangement categories, which determine the payment standard to be used, are:

- Living alone: recipients not sharing expenses with other individuals.
- Sharing Expenses: recipients who share expenses with other individuals.

*Families are exempt from the nonemployability requirement, but must meet financial eligibility requirements.

**Ex-offenders are eligible for two months of General Relief benefits.

- Institutionalized: recipients who are residents of a licensed chronic hospital, nursing home, rest home, approved public medical institution, intermediate care facility, halfway house, or residential treatment center.
- No Household Expenses: recipients who are homeless, living in emergency shelters, or minors living with non-recipient parents.

o Benefit Levels

The following table summarizes the maximum cash grants available to each living arrangement:

<u>MAXIMUM FY86 GR PAYMENT LEVELS</u>				
<u>Family Size</u>	<u>Living Alone</u>	<u>Living With Others</u>	<u>Institutional Residents</u>	<u>No Household Expenses</u>
1	\$244.40	\$162.10	\$55 per individual	\$ 74.60
2	318.10	235.80		148.30
3	391.80	309.50		222.00
4	465.50	383.20		295.70
5	539.20	456.90		369.40
6	612.90	530.60		430.10
Incremental	73.70	73.70		73.70

With the exception of institutional residents, the basic grant in each category is increased by \$73.70 per month for every additional person in the assistance unit. Recipients living in institutions are paid a personal needs allowance of \$55 per month for personal expenses not provided by the institution.

B. Other Services

GR recipients are eligible for other services, including GR Emergency Assistance, the \$90 clothing allowance, and rest home and halfway house payments. Certain recipients are eligible for assistance with SSI applications and appeals. In addition, recipients receive medical services funded in the GR Health Services account (4406-5000). Services funded from the GR account are described below:

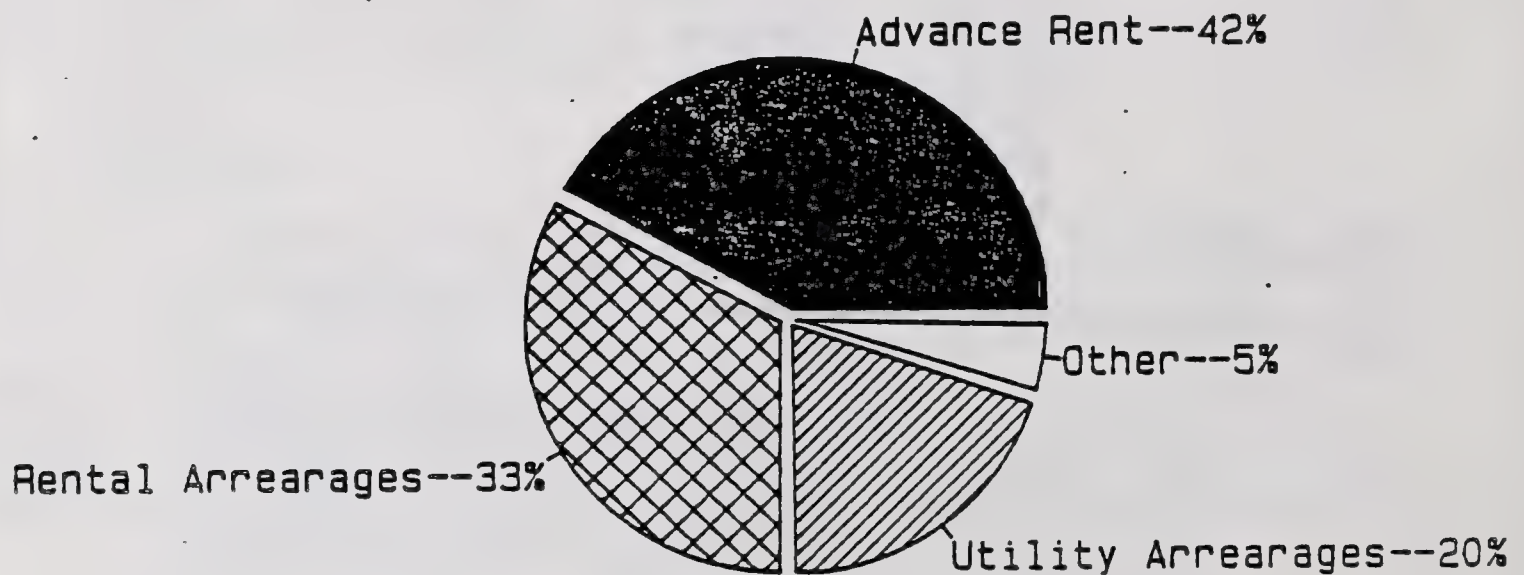
o GR Emergency Assistance

The GR Emergency Assistance program, established in January 1985 provides a variety of services designed to prevent or eliminate homelessness. The program provides payments for

advance rent and security deposits, up to four months of rent and utility arrearages, appliance repairs, and other emergency payments. In the first twelve months of operation, the Department has provided \$1.3 million in EA services.

Advance rent and security deposits account for the largest category of EA usage. As indicated in the chart below, advance rent and security deposits comprised 42% of total expenditures from January-November 1985, followed by rental arrearages (33%), and utility arrearages (20%). Advance rent payments, combined with a smaller Residence Acquisition Program, which existed prior to EA, have enabled 2,000 recipients to establish permanent housing.

GR EMERGENCY ASSISTANCE BY CATEGORY



o \$90 Clothing Allowance

The clothing allowance is a one-time \$90 payment made in September to each household head and dependent. The clothing allowance has been in existence since FY84, and is especially critical to the families on the caseload. FY87 expenditures for the clothing allowance are projected at a total of \$2.7 million.

o Payments to residents of public institutions

The General Relief account provides payments to GR recipients who are residents of certain institutions, including licensed rest homes and nursing homes, halfway houses for the treatment of alcoholism and drug addiction, and residential treatment centers. These recipients receive a \$55 monthly personal needs allowance for personal expenses not covered by the institution. In addition, for those recipients with no other source of income, the Department pays the individual for the per diem costs of residing in the institution. The Department currently provides a personal needs allowance to 1,200 institutionalized recipients and covers the per diem costs for 300 of these recipients. In FY86, the total payments to institutionalized recipients are expected to total \$1.7 million.

o Medical Services

Medical services, funded from the GR Health Services account (4406-5000), provide basic ambulatory care, rehabilitative services, and home health care to GR clients. Under the free care provisions of an agreement between the Department and Massachusetts hospitals in FY85 (Chapter 574, hospital benefits were restored to GR recipients. A preliminary analysis estimates that the total value of the free hospital services available to General Relief recipients under Chapter 574 is approximately \$75 million.

The GR Health Services account funds the vocational rehabilitation component of the GR Choices program.

o Food Stamps

Food Stamps are a critical source of public assistance to approximately 70% of GR clients. These clients receive an average of \$77 per month in Food Stamps. For more information, see the section on the Food Stamp program in this volume.

PROFILE OF THE GR POPULATION

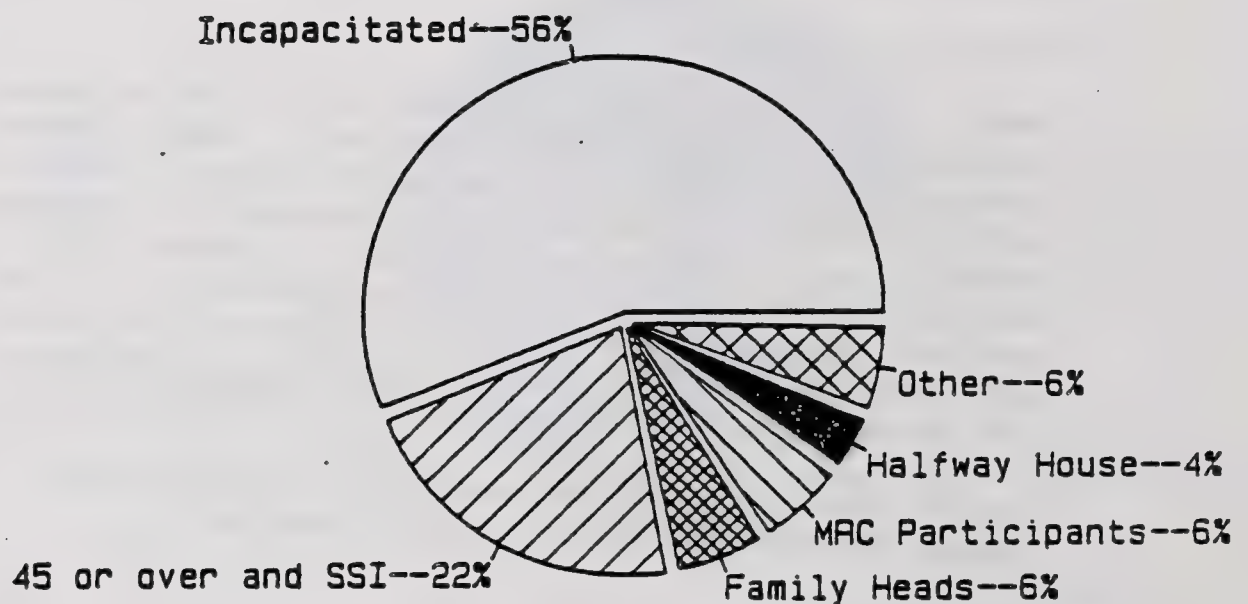
A. Demographics

People receive GR because they are poor, ineligible for other cash assistance programs, and, with the exception of families, are unable to work. The charts on the following pages depict some of the demographic characteristics of the caseload.

o Eligibility Reason

The majority of GR cases, 56%, are non-employable due to a physical or mental disability. An additional 21% are 45 or over and lack a work history, or are SSI applicants awaiting their approval from the Social Security Administration.

ELIGIBILITY REASON OF GR CASES



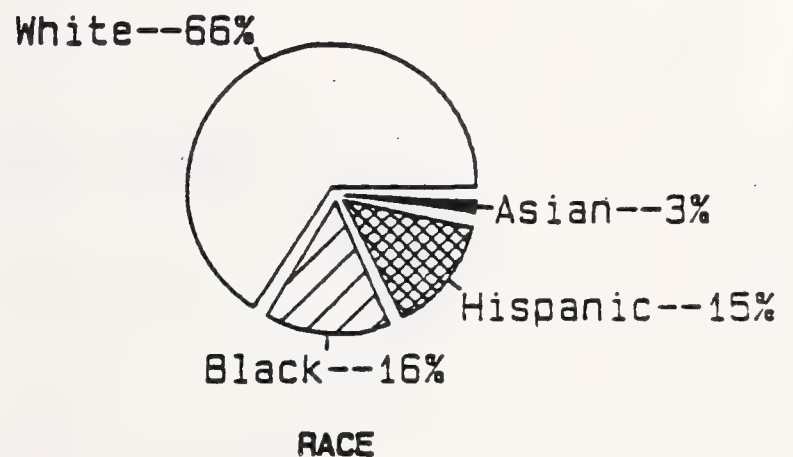
- o Sex

The GR caseload is divided almost equally between men and women. Fifty-one percent are male, and 49% are female.

- o Race

Sixty-six percent of GR heads of household are white. Sixteen percent are black, and 15% are hispanic. Three percent, or 750 cases, are Asian. Asian clients are most likely former recipients of Refugee Assistance, who become eligible for GR after they have been in the United States eighteen months. Benefits for these recipients are fully reimbursed by the federal government for a maximum of eighteen months. Approximately 200 of Asian GR households are families.

GENERAL RELIEF CASELOAD CHARACTERISTICS



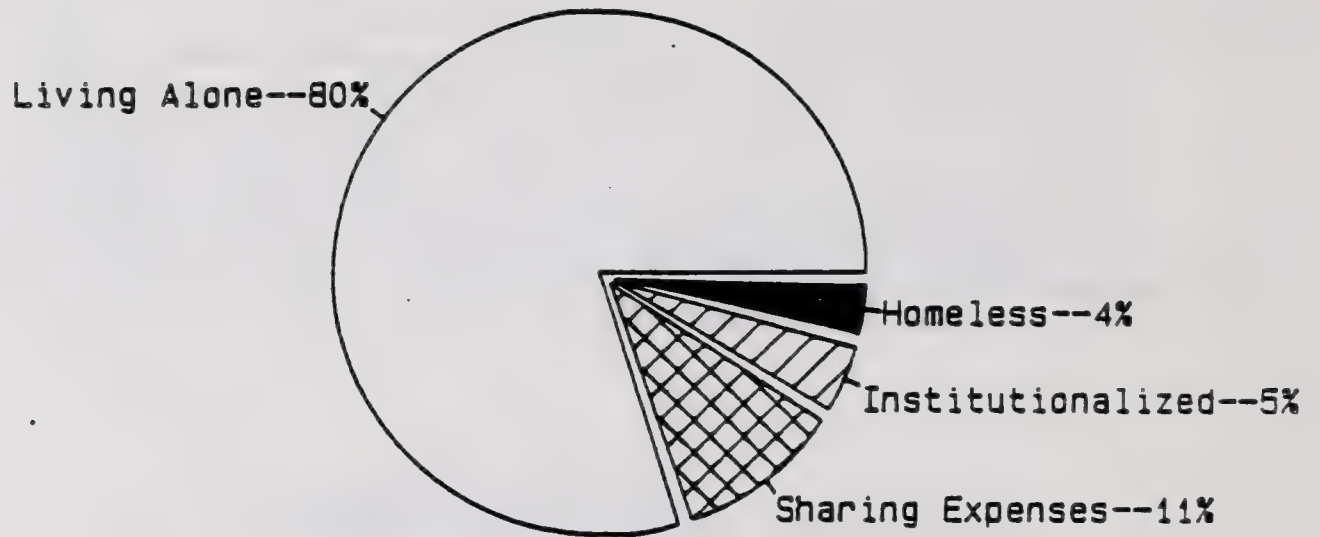
- o Household Size

The overwhelming majority of GR cases, 94%, consists of individuals. Fifteen hundred households are families, with an average of 3.8 members in each.

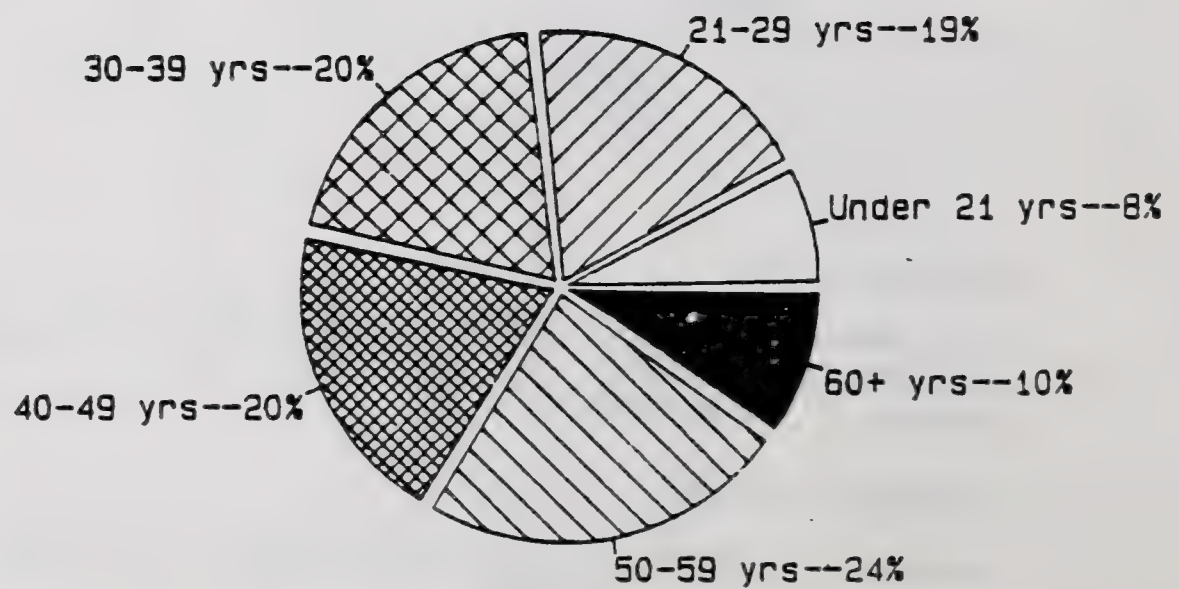
- o Sources of Income

Ninety five percent of recipients receive their only income from the General Relief program. 320 cases, or 1%, have some earned income.

GENERAL RELIEF CASELOAD CHARACTERISTICS



LIVING ARRANGEMENT



AGE OF HOUSEHOLD HEAD

o Age

The median age of GR household heads is 41 years. As indicated in the preceding chart, 8% are under 21, and approximately 20% each are 21-29, 30-39, 40-49, and 50-59. The 500 cases who are 65 or over are primarily applicants for SSI who are awaiting approval for SSI benefits.

o Living Arrangement

A substantial majority of cases, 80%, live alone. Others share living expenses (11%) or are residents of institutions (5%). Approximately 700 recipients are homeless.

o Length of Stay

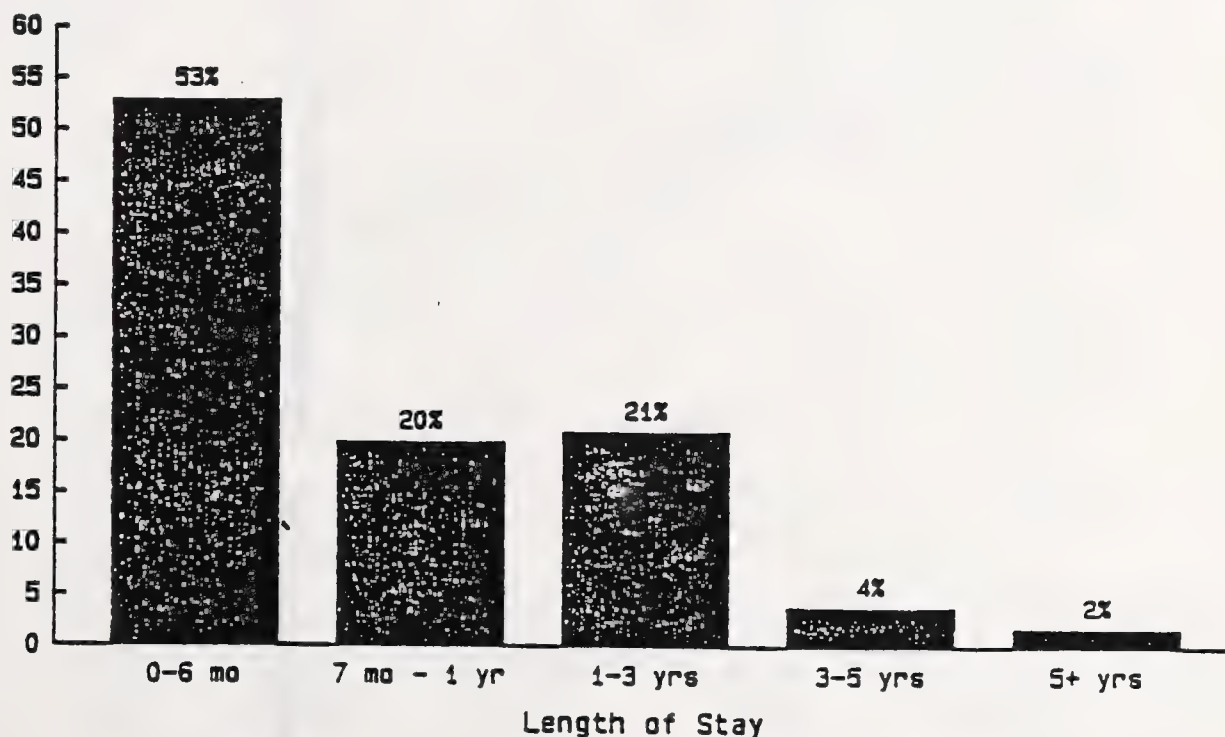
In a sample of closed cases, 70% of all GR cases had been open for less than a year. Only 3% remained on the caseload for more than 5 years.

o Regional Distribution

Twenty-six percent of GR cases are in the Springfield region, 2% in the Boston area, and 16% in the Lawrence region. The remaining 37% of the cases live in the Worcester, greater Boston, and New Bedford areas.

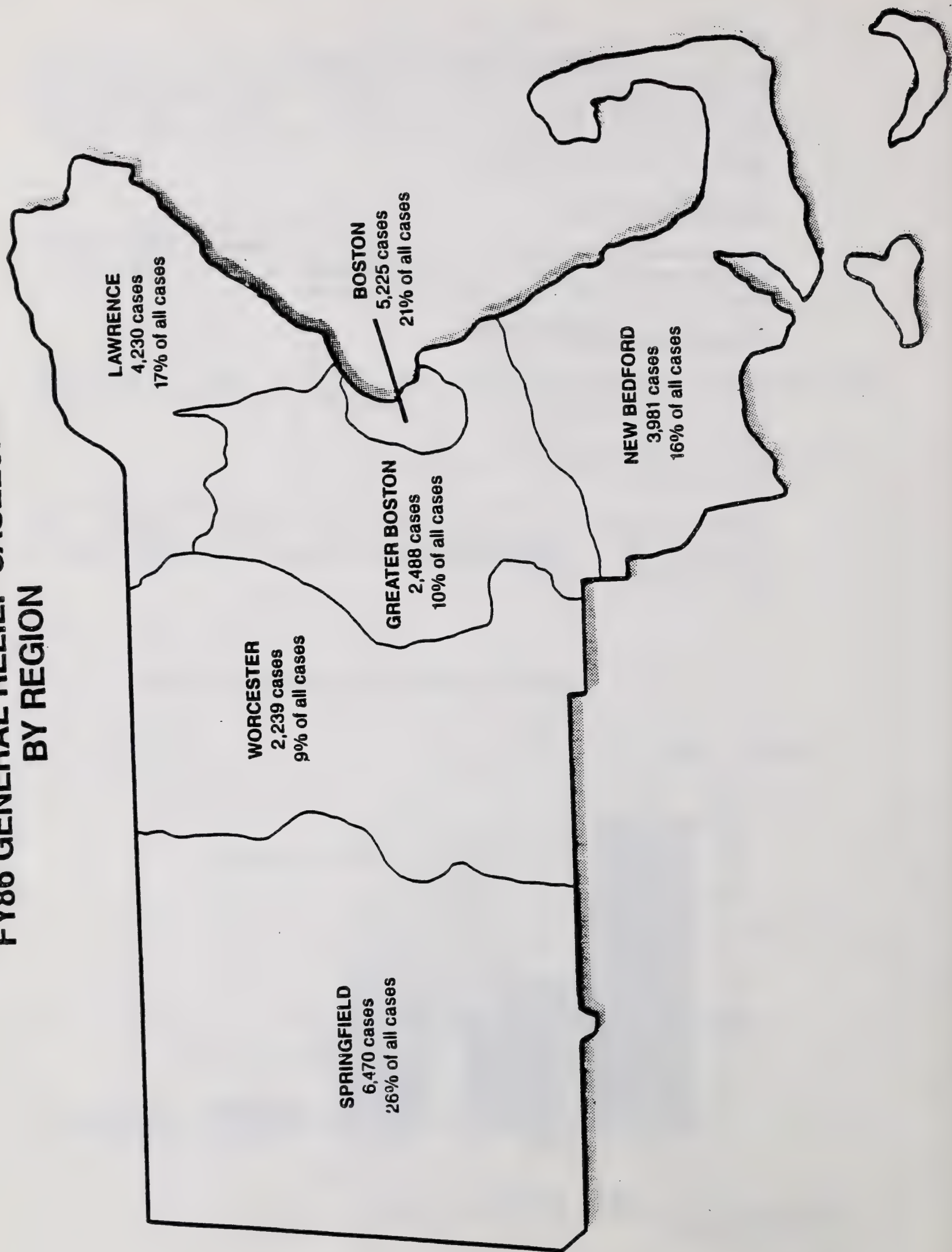
LENGTH OF STAY ON GENERAL RELIEF

Percent of Cases



Data obtained from a sample
of 43,000 closed cases

FY86 GENERAL RELIEF CASELOAD BY REGION



B. Caseload Composition

Each of the eight categories of recipients is described below.

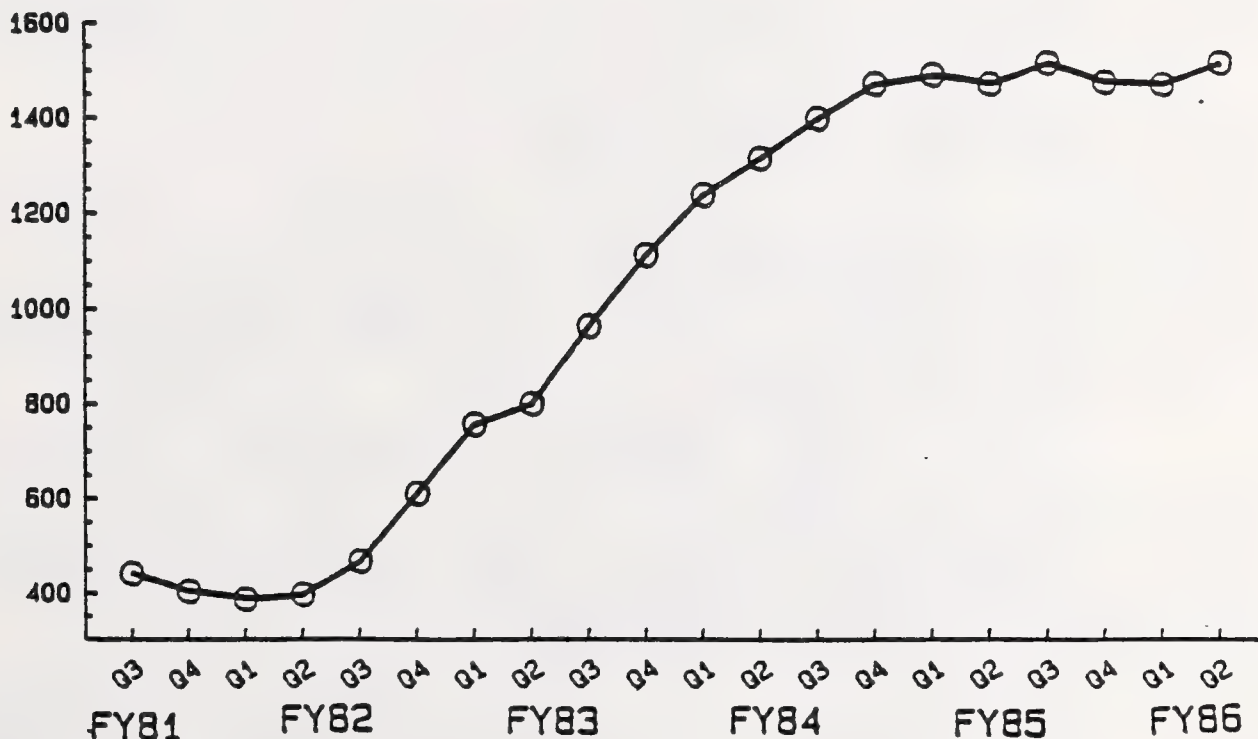
o Families

To be eligible for GR, families must be ineligible for other public assistance programs and must meet appropriate income and asset guidelines. Families are not required to meet the nonemployability standard, as are individuals applying for GR. The maximum eligibility and payment standard for a family of 4 on GR is \$466 per month. Families receiving assistance through GR include households who do not meet AFDC work history requirements, or do not meet the AFDC definition of an eligible household. In addition, GR provides benefits to step-parent families. (Step-parent income must be included in eligibility and grant determinations for an AFDC household but must not be for a GR family.)

As the following graph illustrates, the number of families on GR has nearly quadrupled, from 386 to 1,500, between the first quarter of FY82 and the second quarter of FY86. This is partly the result of the federal Omnibus Budget Reconciliation Act of 1981, which led to the loss of benefits for over 30,000 AFDC families.

NUMBER OF GR FAMILIES
FY81 - FY86

Quarterly Average



Of all families currently on GR, 56% are two-parent households, 16% are single-parent households, and 27% are headed by ineligible grantees who receive benefits on behalf of their children.

The average monthly grant of GR families is \$363. Less than 50, or 2.5%, of GR families have earned income. GR families are twice as likely to have earnings than GR individuals, but are less likely than AFDC families.

The average number of children in GR families is 2.3. Almost three-fifths of GR families have a child 6 years old or less, making parental employment difficult.

o Physically or Mentally Incapacitated

Persons with short-term physical or mental incapacities comprise about three-fifths of GR cases. A doctor must certify that the incapacity will prevent working more than 20 hours per week and will last at least one month. About 50% of incapacitated GR recipients are female. Approximately three-fifths of homeless recipients are in this category.

Although the disabilities of GR recipients are considered short-term in nature, many recipients do suffer from long-term physical and emotional problems. Twenty-one percent of incapacitated recipients currently on the caseload have received GR for between 1 and 3 years, and another 15% have been on GR for more than 3 years.

As a disability must be expected to last at least a year in order for an individual to qualify for SSI, up to 5,000 of these individuals may now be eligible for SSI benefits. GR Choices will focus on assisting these clients in obtaining SSI benefits.

o Age 45 or Over and Lacking a Work History or SSI Applicants

Approximately five thousand needy people who cannot find employment because of their age and lack of work history comprise the second largest caseload group. Individuals must be 45 years of age or older and must not have worked during the six months prior to their application. This group consists of several distinct groups of clients. For example, women whose youngest children are between the ages of 18 and 21 who, prior to the October 1981 passage of OBRA would have been eligible for AFDC, may now receive GR. In addition, 20% of homeless GR recipients qualify through this category.

This category also includes approximately 500 applicants for SSI (primarily individuals age 65 or over) who are receiving interim GR assistance while they await decision from the Social Security Administration.

o Ex-Offenders

The state provides ex-offenders who had been imprisoned for at least two months with GR benefits for up to two months after their release to assist them in making the transition from prison to employment. GR currently assists 400 ex-offenders, and through the first half of FY86 provided benefits to a total of 1,200 individuals. More than 90% of these ex-offenders are men.

o Halfway House Residents

Residents of licensed halfway houses and treatment centers are eligible for GR if they are participating in a training or rehabilitation program. Approximately 1,000 halfway house residents currently receive GR benefits each month. Eighty percent of this group are men.

o Participants in Vocational Rehabilitation Programs

Participants in Massachusetts Rehabilitation Commission training programs for the disabled are eligible for GR. GR benefits enable these individuals to participate in longer-term programs which build skills and contribute to lasting self-sufficiency. Approximately three-fifths of this group are male. The Department aided an average of 1,500 participants each month in the first six months of FY86.

o Full-time Students in Secondary School

Students who attend school full-time through the secondary level can receive GR if they meet income requirements. More than half of the recipients in this group are female. Seventy percent live independently; others share expenses (17%) or have no reported expenses (9%).

As mandated by the Cumby-Lopez court decision, in FY86, the Department removed the age restriction on recipients in this category. Previously, low-income, full-time students were eligible for GR only until their nineteenth birthday. Current policy enables them to continue receiving GR benefits until they complete their high school education, regardless of their age. GR currently assists 250 students 19 or older.

o Persons Caring for the Incapacitated

Individuals are eligible for GR if they are unable to work because they provide full-time care to an incapacitated GR or SSI recipient who lives in their home. In the absence of this provision, more GR and SSI recipients would be institutionalized, at a greater cost to the state. Eighty-five percent of the 300 people in this category are women.

CASELOAD TRENDS

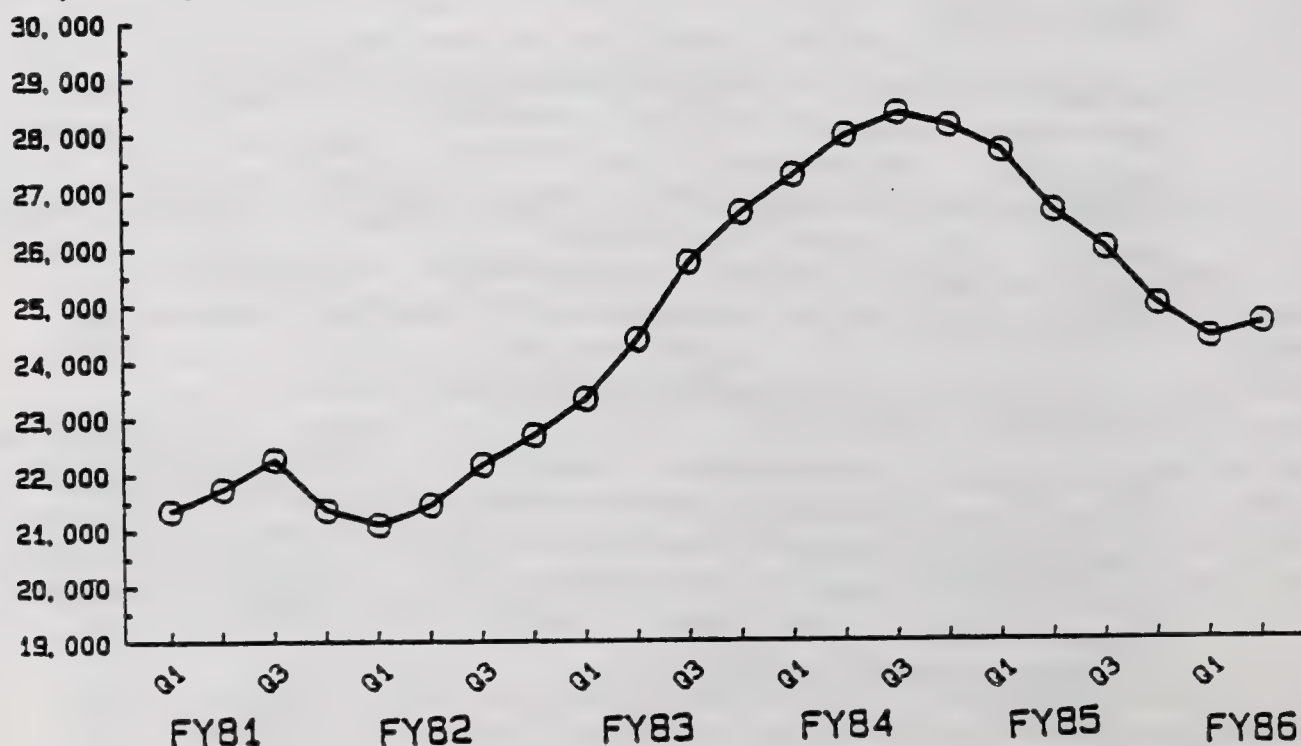
As the following graph indicates, the GR caseload grew substantially between FY81 and FY84, increasing 28%. As described previously, this increase occurred as the Department responded to the needs of former AFDC, SSI, and Social Security Disability Insurance (SSDI) recipients who lost their benefits due to restrictive federal policy changes. In addition, as a result of Chapter 450, "An Act to Assist the Homeless," passed in October 1983, the Department aids 700 homeless men and women.

The caseload declined by 6%, or 1,600 cases, in FY85. The GR Employment and Training program and an increased rate of GR to SSI conversions, combined with an expanding economy, have contributed to this decline. Although the caseload has increased by approximately 50 cases per month in FY86, the current level of 24,900 is 2% lower than in January 1983.

In FY87, the caseload is expected to increase moderately. While services such as GR Choices will continue to exert downward pressure on the caseload, several factors will exert upward pressure. These include continuing efforts to assist the homeless, and the resumption of federal Social Security and SSI continuing disability reviews. These reviews were terminated in 1984 following strong protest by Massachusetts and other states. The resumption of the reviews in January 1986 will result in terminations from the SSI and SSDI programs, and these individuals may then qualify for GR.

GENERAL RELIEF CASELOAD FY81 - FY86

Quarterly Average



FY87 REQUEST

The FY87 request contains a critical 10% cost-of-living increase, as well as continued funding for such essential services as Emergency Assistance, the clothing allowance, and GR Choices.

1. Direct Payments	\$75,958,428
2. Payments to GET recipients	232,400
3. Retroactive payments to SSI recipients	3,800,000
4. 10% cost-of-living increase	7,250,000
5. Emergency Assistance	3,500,000
6. \$90 Clothing allowance	2,702,847
7. Non-medical vendor payments	
o Protective payments	700,000
o Advances and other payments	700,000
8. Services to increase SSI conversions	
o Legal services	500,000
o Massachusetts Rehabilitation Commission	200,000
9. Legal fees	50,000
10. Refunds	(12,000,000)
11. MPACS savings	<u>(400,000)</u>
Total Expenditures	\$83,193,675

Funded in Other Accounts

11. GR Health Services*	\$16,000,000
12. GR Employment and Training Services	2,392,000

- * Includes \$500,000 in GR Choices vocational rehabilitation by the Massachusetts Rehabilitation Commission.

1. Direct Payments \$75,958,428

Direct payments are the twice monthly checks paid directly to GR recipients. The FY87 projection assumes an average monthly caseload of 25,627 and an average monthly grant of \$247, before the 10% cost of living increase.

The 10% cost of living increase will raise the average monthly grant to \$271 for individuals and \$399 for the 1,500 families on the caseload.

2. Direct Payments to GET Recipients \$232,400

The Grant for Education and Training program (GET) provides a monthly stipend of \$76 to low-income, full-time students between

the ages of 18 and 21 who are living at home. The grants, a response to restrictive federal AFDC policy changes, enable full-time students whose AFDC benefits have been terminated to complete their high school education. Estimated expenditures assume a monthly average caseload of 250.

3. Retroactive Payments to SSI Recipients \$3,800,000

Payments to SSI applicants are the retroactive payments made by the Social Security Administration through the Department to GR recipients whose applications for SSI have been approved. These payments represent the difference between the higher SSI grant to be paid to the recipients and lower GR benefits they received while they were awaiting approval by the Social Security Administration.

4. 10% Cost of Living Increase \$7,250,000

In order to improve the adequacy of GR benefits, the Department is requesting a 10% cost of living increase. This increase is urgently needed to enable recipients' grants both to keep up with inflation and to be sufficient to prevent homelessness.

5. Emergency Assistance \$3,500,000

The GR Emergency Assistance program, which extends the AFDC Emergency Assistance program to GR recipients, began on January 1, 1985. GR Emergency Assistance provides payments for advance rent and security deposits, up to four months of rent and utility arrearages, and other emergency payments to prevent homelessness. In FY87, the Department will provide \$3.5 million in GR Emergency Assistance services.

6. Clothing Allowance \$2,702,847

The clothing allowance is a one-time payment to each recipient eligible for GR benefits. In September of FY87, GR recipients will receive \$90 and GET recipients will receive the AFDC clothing allowance of \$125.

7. Non-Medical Vendor Payments

o Protective payments \$700,000

Protective payments are made on behalf of recipients to landlords, utilities, grocery stores, halfway houses and other vendors. FY87 expenditures are projected at approximately 0.9% of FY87 direct expenditures.

o Advance and other non-medical vendor payments \$700,000

Advance payments include payments for rent, groceries, and other basic services for recipients while they await the receipt of their first check. Other non-medical vendor

payments include funeral costs and other expenditures. Estimated expenditures are approximately 0.9% of FY87 direct payments.

8. Services to Increase SSI Conversions \$700,000

The GR Choices program, established in FY86 to offer clients alternatives to welfare, will continue in FY87 with a full year of funding for the service providers funded in this account:

o Massachusetts Rehabilitation Commission \$200,000

Through a full year of the interagency agreement with the MRC, clients with a high potential for rehabilitation will be offered employment and training or vocational rehabilitation services, with the goal of unsubsidized employment. Those who are too severely disabled to participate in these programs will receive assistance with their SSI applications. The GR account funds the GR/SSI component of this agreement, while the GR Health Services account (4406-5000) funds rehabilitative services.

o Legal Services Advocacy .. \$500,000

The Department will fund a full year of services with legal service agencies to assist and represent clients in overturning their SSI denials.

9. Legal Fees \$50,000

Legal fees include payments for certain court-ordered costs of recipients.

10. Refunds (\$12,000,000)

The bulk of refunds consists of retroactive payments from the Social Security Administration to the Department for SSI applicants whose applications for SSI were approved. A portion of these refunds is retained by the Department as reimbursement for GR grants provided while the applicants were awaiting decision on the SSI applications. The remainder is paid to recipients and represents the difference between SSI and GR benefits for the period they were on GR. FY87 projected refunds of \$12 million are equivalent to FY86 levels, accounting for the net effect of increased cases approved for SSI through the GR Choices program and federal policies which may limit the number of approvals.

11. MPACS Savings (\$400,000)

The Massachusetts Public Assistance Control System (MPACS) is the Department's new eligibility determination and benefits issuance computer system. MPACS will be implemented during FY87 and will result in \$400,000 in FY87 savings in the GR program.

SUPPLEMENTAL SECURITY INCOME (4405-2000)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures/ Appropriation	\$107,147,520	\$111,130,297	\$114,463,957*	\$115,007,871
Caseload	103,526	105,855	107,512	107,715

The Supplemental Security Income (SSI) program is a federally-administered, but partly state-funded, program that provides cash assistance to financially needy individuals who are elderly, blind, or suffering from a long-term physical or mental disability. SSI benefits consist of a basic payment funded by the federal government and an optional state supplement funded by the states if they so choose. The Department's SSI account funds state supplements to the aged and disabled, while the Massachusetts Commission for the Blind funds benefits to blind recipients. In FY85, the Department provided assistance to an average of 105,855 cases per month, of whom 51%, or 54,155, were elderly and 49%, or 51,700, were disabled. With estimated FY86 expenditures of almost \$114.5 million, the SSI account is the Department's second largest cash assistance program, second only to AFDC.

PERFORMANCE 1983-1986

SSI is administered by the federal government through the Social Security Administration. The federal government establishes policies, performs eligibility determinations, and sets minimum federal payment standards. Massachusetts has taken an active role in responding to restrictive federal changes in SSI policies, and in providing essential benefits to recipients. As a result, Massachusetts' state supplements are the fourth highest in the nation, and combined state and federal benefit levels are above the poverty level.

Between FY84 and FY86, the Department has served recipients in the following ways:

- o Maintained cash grants at or above the poverty level;
- o Led the fight against restrictive federal disability reviews;
- o Improved and expanded essential services; and
- o Improved the management of the SSI program.

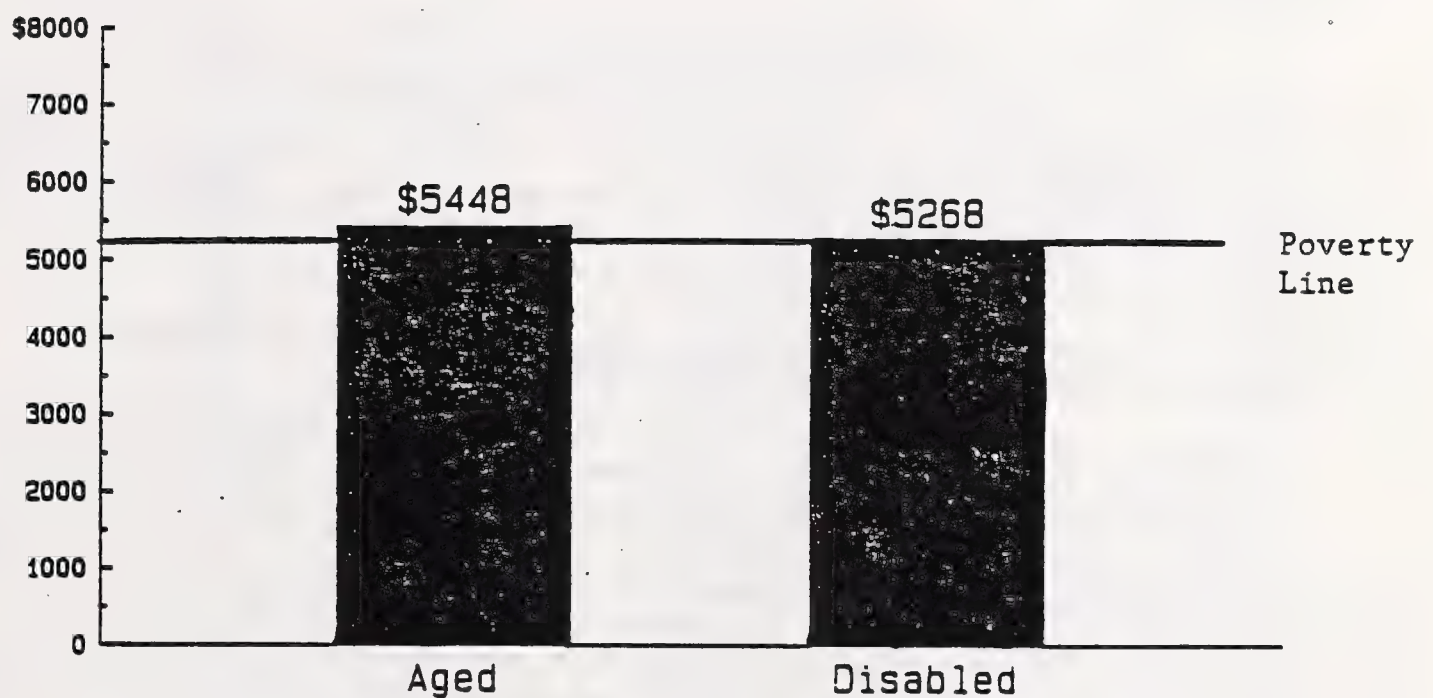
These accomplishments are described briefly below.

* Includes \$7.2 million prior appropriation.

A. Maintained Cash Grants At Or Above The Poverty Level

Between FY84 and FY86, the Department has succeeded in maintaining SSI benefits at or above the poverty level. As the chart indicates, SSI benefits for the elderly and disabled, currently at 104% and 100% of the poverty line, are higher than any other cash assistance program funded by the Department. SSI benefit levels are almost twice as high as those of General Relief.

SSI BENEFITS COMPARED TO THE POVERTY LINE



1985 Poverty Line for
an individual is \$5250

In addition, Massachusetts state supplement standards are the fourth highest in the nation, lower only than California, Alaska, and Connecticut. The Department has maintained high SSI benefits by passing onto SSI recipients the full 3.1% federal cost-of-living increase on January 1, 1986. Under this "pass-along" policy, states have the option of reducing their state supplement levels within certain limits whenever a federal cost of living adjustment (CoL) is issued. This policy is a provision of the Social Security Act of 1978. Specifically, the regulations allow states to maintain the same state supplement levels for each recipient or to reduce supplements, provided that total expenditures remain at least as high as in the previous year. In each of the previous four regular CoL increases, Massachusetts chose to pass along the full increase, with the exception of moderate adjustments to certain living arrangement standards.

In addition to maintaining high state supplements, Massachusetts has doubled its share of the monthly personal needs allowance (PNA) for SSI recipients in nursing homes and long-term care institutions. This payment is provided for the cost of recipients' personal articles that are not covered by the institution. Between FY84 and FY86, the federal government's share of this payment remained at \$25, while the state's share increased from \$20 to \$30.

B. Led the Fight Against Restrictive Federal Disability Reviews

Between 1980 and 1984, almost 7,000 Social Security Disability Insurance (SSDI) and SSI recipients lost their benefits after the Reagan administration increased the frequency of redeterminations or "continuing disability reviews" (CDR) of cases who had already demonstrated long-term disability. Faced with the loss of their income, many of these individuals began receiving General Relief benefits. GR payment standards are almost 50% lower than SSI, but represent a higher cost to the state because they are 100% state funded. Many other recipients received no assistance at all, as they were not able to navigate the service delivery system.

Massachusetts and other states responded aggressively to these terminations, which were based on incomplete documentation and inappropriate standards. Governor Dukakis issued a directive which ordered that case reviews be based on complete medical evidence and more appropriate standards of review. In addition, the Massachusetts legislature established the Disability Benefits Project to provide legal assistance to former SSDI and SSI recipients appealing their terminations. Finally, the Avery class action suit was filed against the Social Security Administration in Massachusetts and 32 other states. As a result, the federal government stopped performing CDRs in April 1984. The December 1984 Avery court decision mandated that elements of the Governor's directive be implemented as federal policy.

Since the termination of CDRs and the Avery court decision in 1984, the number of cases approved for SSI has increased dramatically. Between FY84 and FY85, the number of GR cases converted to the SSI program increased 60%.

The Department has continued its efforts to make SSI benefits available to all eligible individuals. As part of the GR Choices program, the Department has established contracts providing legal assistance to General Relief recipients applying for SSI benefits and appealing SSI denials.

C. Expanded Essential Services

While the Department plays only a limited role in establishing SSI policies and eligibility standards, between FY84 and FY86 Massachusetts has expanded a variety of essential services available to SSI recipients. These services include:

o Expanded Emergency Needs Program

State legislation that went into effect in March 1984 increased the maximum allowable payment for funeral expenses for SSI recipients from \$300 to \$1,100. This increase enabled funeral payments to reflect rising costs. SSI funeral expenses, for which the Department paid \$850,000 in FY85, are the most frequently utilized service in the SSI Emergency Needs program, which provides payments in the event of national disaster, fire, or death.

o \$1 million in Rest Home Vendor Payment Rate Increases

Rest homes are residential facilities for elderly individuals who require minimal medical care. When an SSI recipient's income, including the SSI grant, is insufficient to pay the cost of residing in a rest home, the Department pays the difference to the home. The Department makes payments to rest homes of more than \$8 million per year on behalf of approximately 4,000 SSI recipients. Through calendar year 1983, rest home rates, set by the Rate Setting Commission, were capped at \$19.62 per day. In 1985, the Rate Setting Commission adjusted the rates for calendar years 1984 and 1985, based on a new methodology for establishing rates. In FY86, the Department has paid approximately \$1 million in retroactive rate increases based on these new rates.

o Provided Training and Employment Opportunities for the Disabled.

The Department, through the ET program, is committed to providing opportunities to all recipients. In FY86, the Department is sponsoring a supported work program for the mentally disabled. This program, funded by the Department and administered by the Department of Mental Health, places

individuals into worksites where they receive training, counseling, peer support, and close supervision to enable them to eventually obtain unsubsidized employment. In FY86, the program will serve 200 disabled individuals, of whom 60% are SSI and General Relief recipients.

To facilitate disabled individuals' transition to employment, the Department has supported Congress' extension of Section 1619 of the Social Security Disability Act of 1980. This policy allows disabled individuals with earnings above allowable SSI levels to retain their SSI benefits. Previously, disabled individuals with earnings of more than \$300 per month were ineligible for SSI. In addition, Section 1619 allows certain disabled individuals with earnings that are too high to be eligible for SSI benefits to retain Medicaid benefits. Section 1619 was recently extended by Congress through June 1987. This policy provides a critical incentive to employment for the recipients participating in the supported work and GR Choices programs.

D. Improved Management of the SSI Program

Under the federally-administered, but state-funded, supplement program, the Social Security Administration (SSA) bills the Department each month for the state's share of SSI payments to recipients. In FY84, an internal SSA audit revealed that the federal government had consistently overbilled Massachusetts for SSI payments during federal fiscal years 1974 through 1982. As a result, in FY85 the Social Security Administration credited the Department with \$7.3 million for these overpayments.

In FY86, the Department contracted with an accounting firm to audit SSA's billing system. The results of the audit will be used to improve the Department's accounting of the more than \$100 million per year it pays to the federal government, and to ensure that Massachusetts pays the appropriate amount every month. In addition, the Department will take steps to recover from the federal government whatever sums the auditors discover are owed to Massachusetts.

FY87 INITIATIVES

In FY87, the Department will continue to build upon the progress it has made in pursuing these critical goals during the past three years.

A. Maintain High Benefit Levels: Full Pass-Along of Federal CoL Increases

The Department has passed through to recipients the full 3.1% federal CoL issued in January 1, 1986. Because of the federal-state SSI payment formula, maintaining current state supplement levels will cost the Department up to \$1 million, with one half of this cost in FY86 and the remaining half in FY87. The full federal CoL increase

will guarantee Massachusetts SSI recipients incomes of up to 104% of the poverty line.

B. Assist Applicants with SSI Eligibility

Two initiatives funded by the General Relief account (4406-2000) will enable GR recipients to convert to the SSI program. Almost 60%, or 14,000, of current GR recipients are disabled, and more than one-third of these recipients have been on GR longer than a year. They may therefore be eligible for SSI benefits, which are almost twice as high as GR benefits and provide full Medicaid coverage. The Department has contracted through mid-FY87 with legal service agencies and the Massachusetts Rehabilitation Commission to assist SSI applicants through the complex application and appeals process. These contracts will convert over 500 GR recipients to SSI. The Department plans to renew these contracts to provide a full year of services in FY87.

THE SSI PROGRAM

A. Eligibility Requirements

To qualify for the SSI program, a person must satisfy both categorical and financial eligibility criteria.

o Categorical requirements for the aged and disabled are:

- Aged - an individual 65 years or older;
- Disabled - an individual who is unable to work as a result of a medically determined physical or mental impairment. The disability must be expected to last at least 12 consecutive months or to result in death. In addition, a severely disabled child under 18 may be eligible.

o Financial Requirements

If an applicant meets one of the above categorical requirements, he or she must also demonstrate financial eligibility. Both income and assets are considered in this determination.

- Assets

The assets of an individual applicant must not exceed \$1,600, while a couple's assets must be less than \$2,400.

- Income

The Social Security Administration allows several deductions for earned and unearned income. Because of the SSI payment formula, an applicant can have as much as \$713 in monthly income and still be eligible for SSI.

The following income deductions are allowed when determining eligibility and grant levels:

- \$20 disregard - the first \$20 of an applicant's earned or unearned income is disregarded. Unearned income includes Social Security benefits, pensions, veterans benefits, and interest income.
- \$65 work-related expense deduction - applicants with earnings are allowed a \$65 monthly deduction for work-related expenses.
- 50% earned income deduction - 50% of any remaining earned income is deducted from the payment standard.

After these deductions are taken, the remaining income, called "countable income," is compared with the payment standards, which vary depending on the category (aged or disabled), the living arrangement, and whether the applicant is an individual or member of a couple. If the countable income exceeds the standard, the applicant is ineligible; if income is less than the standard, the individual is eligible for a cash benefit equal to the difference between the payment standard and the countable income.

B. Benefit Levels

Benefit levels for cash grants are a combination of the federal basic payment and the state supplemental payment. The benefit that an individual is eligible for depends on his or her category (aged, disabled or blind), living arrangement, and the amount of countable income. The chart on the preceding page presents SSI payment standards. The maximum payment for an aged individual is \$465 per month, made up of a \$336 federal share and \$129 state share. A description of each of the components in the grant calculation is provided below:

o Category of Eligibility

While federal payment standards are uniform for aged and disabled recipients, state supplements vary. With the exception of rest home residents, the state's maximum supplement for aged recipients is \$129, while the maximum state supplement for the disabled is \$114. An aged recipient who lives alone and has no countable income is eligible for up to \$465 per month in combined federal and state benefits, while a disabled individual may receive up to \$450 per month.

o Living Arrangement Categories

Benefit levels vary to account for differences in the cost of maintaining recipients' living arrangements. Those who share living expenses or live in the household of another receive

less than those who live alone. The five living arrangement categories are:

- Full Cost of Living. Individuals who live alone or with their families, and who pay their full share of living expenses are included in this category. In addition, this category includes individuals living in private congregate housing, in order to encourage group living among the elderly.
- Shared Living Expenses. Individuals who share household expenses with others and who do not meet the criteria for other living arrangement categories.
- Household of Another. Individuals who live in the household of another and are determined by the Social Security Administration to be receiving in-kind support, such as food and shelter. This in-kind support results in a 33 and 1/3% reduction in the federal SSI benefit rate.
- Domiciliary Care. Individuals residing in a licensed rest home are included in this category.
- Long-term Care Institutions. SSI recipients who reside in Title XIX (Medicaid) institutions, typically nursing homes and chronic disease and rehabilitation hospitals, are entitled to a maximum monthly personal needs allowance of \$55. Of this amount, the federal government pays up to \$25 monthly, and the state pays an additional \$30.

o Income Deductions

Earned or unearned income is deducted from the maximum payment standards according to the formula described earlier. Recipients with no sources of outside income receive the full amount of the payment standard. The SSI payment formula requires that any income be used to reduce the federal share of SSI payments first. The following example demonstrates the benefits calculation for an individual with unearned income.

SSI MONTHLY PAYMENT STANDARDS
(Effective 1/1/86)

<u>INDIVIDUAL</u>		<u>Aged</u>	<u>Disabled</u>	<u>Blind</u>
Full Cost of Living	Federal Payment	\$336.00	\$336.00	\$336.00
	State Supplement	128.82	114.39	149.74
	Total Standard	464.82	450.39	485.74
Shared Living Expenses	Federal Payment	\$336.00	\$336.00	\$336.00
	State Supplement	39.26	30.40	149.74
	Total Standard	375.26	366.40	485.74
Household of Another*	Federal Payment	\$224.00	\$224.00	\$224.00
	State Supplement	104.36	87.58	261.74
	Total Standard	328.36	311.58	485.74
Rest Home	Federal Payment	\$336.00	\$336.00	\$336.00
	State Supplement	171.58	171.58	149.74
	Total Standard	507.58	507.58	485.74

<u>MEMBER OF A COUPLE</u>		<u>Aged</u>	<u>Disabled</u>	<u>Blind</u>
Full Cost of Living	Federal Payment	\$252.00	\$252.00	\$252.00
	State Supplement	100.86	90.03	233.74
	Total Standard	352.86	342.03	485.74
Shared Living Expenses	Federal Payment	\$252.00	\$250.00	\$250.00
	State Supplement	100.86	90.03	233.74
	Total Standard	352.86	342.03	485.74
Household of Another*	Federal Payment	\$168.00	\$168.00	\$168.00
	State Supplement	107.90	97.09	317.74
	Total Standard	275.90	265.09	485.74
Rest Home	Federal Payment	\$252.00	\$252.00	\$252.00
	State Supplement	252.58	252.58	233.74
	Total Standard	504.58	504.58	485.74

* One-third of the federal payment standard is deducted as in-kind income for people in this category. The table shows the payment after this computation.

ELDERLY INDIVIDUAL, LIVING ALONE, WITH \$300 PER MONTH IN UNEARNED INCOME

<u>Outside Income</u>			<u>Maximum Federal Payment</u>	<u>State Supplement</u>	<u>Maximum Total SSI Payment</u>
Social Security	\$100	Maximum Payment	\$336	+	\$129 = \$465
Private Pension	+ 200	Countable Income	<u>-280</u>	+	<u>- 0</u> = <u>-280</u>
Total	\$300	SSI Grant	\$ 56	+	\$129 = \$185
\$20 Disregard	<u>- 20</u>				
Countable Income	\$280				

As indicated in the example above, the individual's grant, which totals \$185, is composed of a \$56 federal share and a \$129 state share. The state's share exceeds the federal government's share because income reduces the federal maximum payment before the state maximum payment.

Because of this payment formula, total annual state SSI payments equal almost 40% of total combined federal and state payments. This occurs despite the fact that the state supplement of \$129 for an aged individual is only 28% of the total federal plus state payment standard of \$465.

The average combined monthly benefit of Massachusetts SSI recipients is \$238. The average state share of this grant is \$83 per month.

o Non-Cash Benefits

In addition to the cash payments administered by the federal Social Security Administration, SSI recipients are eligible to participate in two state-administered Department programs: Food Stamps and Medicaid. SSI recipients receive full Medicaid coverage. The average annual cost of Medicaid benefits for SSI recipients is \$2,100 for the aged and \$3,900 for the disabled. Approximately 28% of SSI recipients receive Food Stamp allotments, with an average monthly value of \$35.

CASELOAD CHARACTERISTICS

The following charts show some of the demographic characteristics of the aged and disabled recipients of SSI.

- o Sex

A substantial majority of aged recipients (80%) are female, as are 57% of the disabled.

- o Living Arrangement

Ninety-one percent of SSI recipients reside in the community, 4% in rest homes, and 5% in nursing homes and other long-term care institutions.

- o Source of Income

Fifty eight percent of all SSI recipients receive Social Security benefits of approximately \$330 per month. Seventy-eight percent of the aged receive Social Security, compared to 36% of the disabled. In addition, 46% of the aged and 26% of the disabled have other sources of unearned income. The reason for this discrepancy between the proportion of aged and disabled having other sources of income may be that many of the elderly now receiving SSI have had a lifetime of employment, which may have made them eligible for Social Security benefits and limited pension plans. Many of the disabled population, on the other hand, have had, at best, intermittent employment.

D. CASELOAD TRENDS

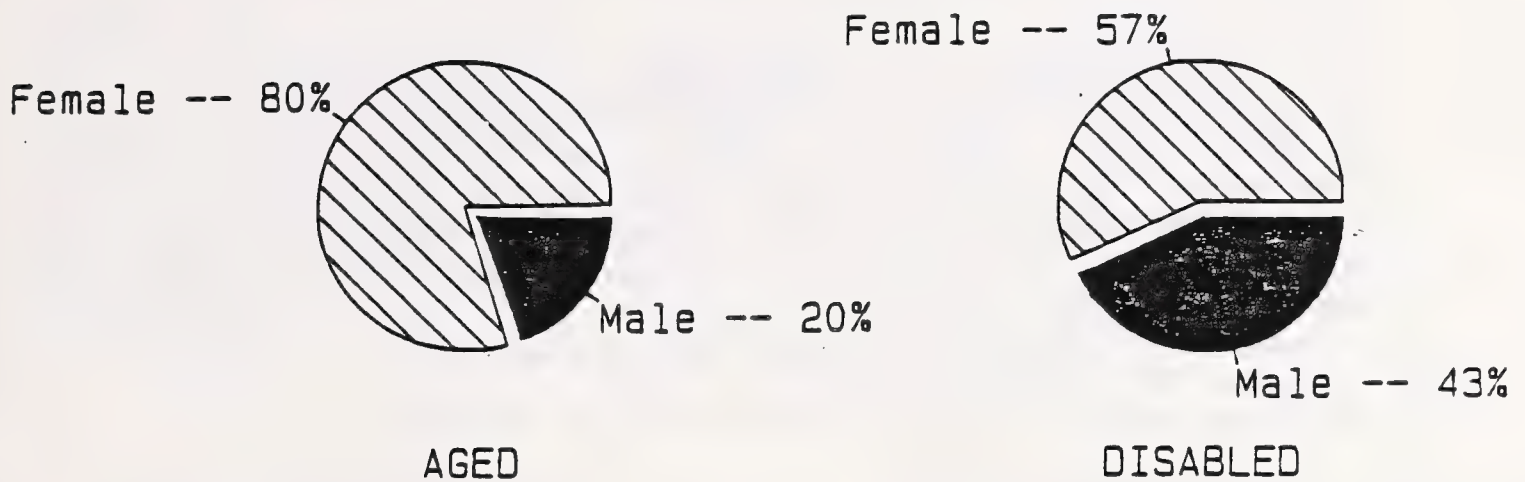
From FY80 to FY84, the SSI caseload decreased sharply, from 123,356 to 103,526 cases. From FY84 to FY86 the caseload increased 4%, to 107,385. These changes mask two distinct trends in the aged and disabled caseloads; the aged caseload has decreased sharply, while the disabled caseload remained relatively stable until FY83, when it began to increase.

As the chart below demonstrates, in June 1985, the disabled caseload exceeded the aged caseload for the first time in the SSI program's history.

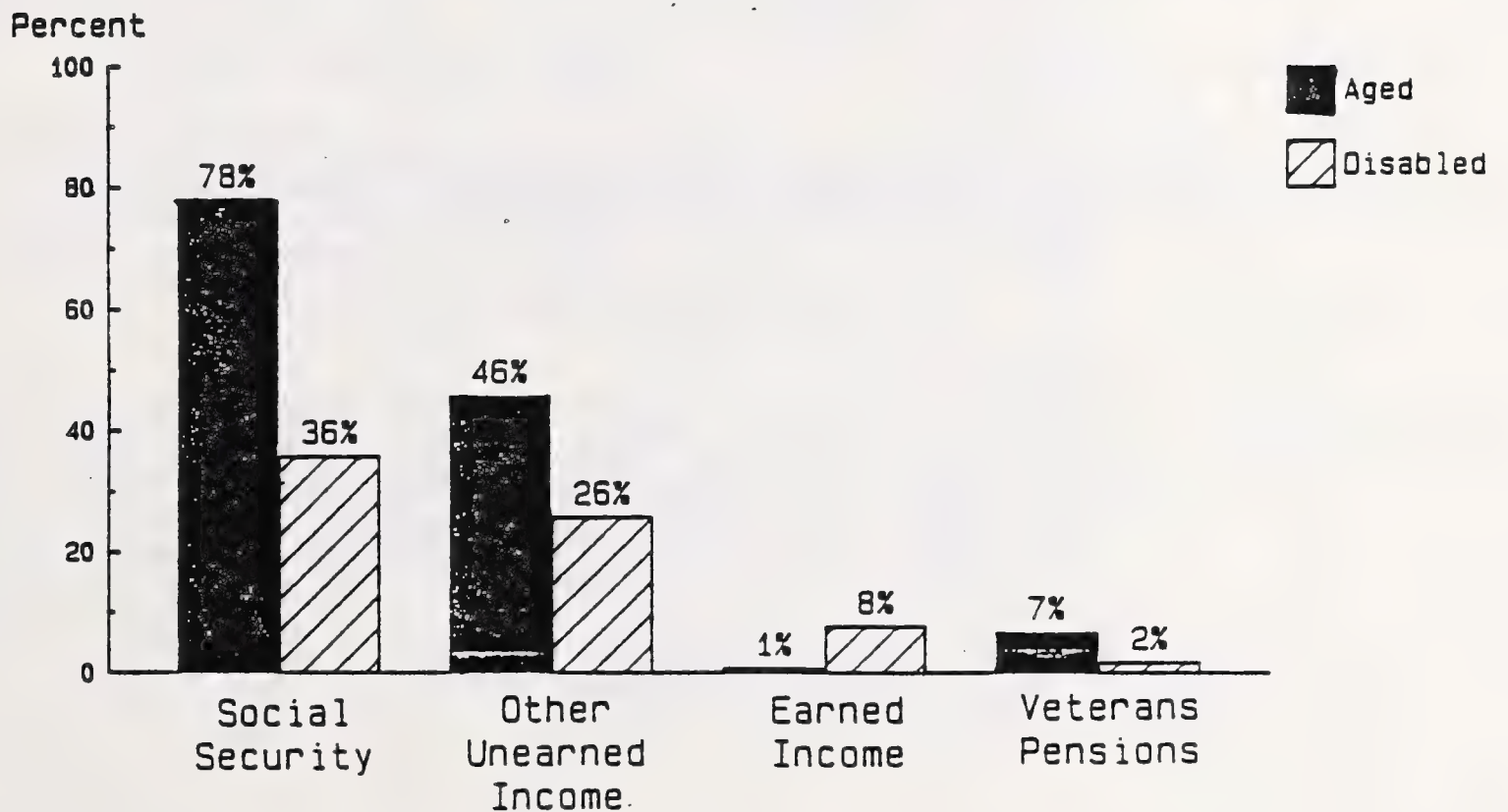
- o Decreasing aged caseload

The 25%, 18,000 case decrease in the aged caseload between FY80 and FY86 occurred despite the fact that the elderly population in Massachusetts has increased by 7%, or 50,000. Primarily because of increases in Social Security benefits, fewer elderly people have income below the SSI payment standard. Approximately 90% of the elderly in this country receive Social Security benefits. The average retired Social Security recipient currently receives \$478

CHARACTERISTICS OF THE SSI AGED AND DISABLED CASELOAD



SSI RECIPIENTS WITH OTHER INCOME



per month, a figure that is barely below the SSI allowable eligibility levels.

o Increasing disabled caseload

The disabled caseload decreased by 3,500 cases from FY80 to FY83, then increased 10%, or 5,000 cases, from FY83 to FY86. These changes are the result of federal policy changes. In April 1984, the federal government suspended its continuing disability reviews (CDRs) following protests and legal actions by Massachusetts and other states. In FY85 few recipients were terminated for medical reasons. This was reflected in both the SSI and GR caseloads. Between FY84 and FY85, the number of GR cases who closed off GR because they were approved for SSI benefits increased by 60%, from 2,060 to 3,300.

o FY87 caseload projection

The SSI caseload, projected at 107,512 in FY86, is expected to increase to 107,715 in FY87. This slight increase is the net result of two opposing trends:

- GR Choices initiatives and liberalized mental disability guidelines will increase the caseload. GR Choices contracts with legal service agencies and with the Massachusetts Rehabilitation Commission will increase the number of GR to SSI conversions by approximately 500 cases. In addition, liberalized mental disability guidelines recently established by the federal government will, when fully enacted, enable more clients with mental disabilities to be approved for SSI benefits.
- Decreasing aged caseload and resumption of continuing disability reviews will result in caseload decreases. The decrease in the aged caseload will continue throughout FY87. With a Social Security cost-of-living increase expected to occur in January 1987, fewer elderly individuals will be eligible for SSI benefits.

In addition, the Social Security Administration resumed continuing disability reviews (CDRs) in January 1986. While the federal government will utilize more flexible review standards than during the previous period of reviews, terminations of disabled cases will occur throughout FY87.

The net result of these factors is an FY87 projected caseload of 107,715, less than 1% higher than in FY86.

FY87 REQUEST

1. Direct Payments	\$103,024,222
2. Long-term Care Personal Needs Allowance	1,499,649
3. Rest Home Vendor Payments	8,300,000
4. Emergency Needs	2,184,000
	<u>\$115,007,871</u>

1. Direct Payments \$103,024,222

Direct payments are the state's share of the SSI benefits to aged and disabled recipients. The FY87 projection of \$103 million represents monthly payments to 102,867 non-institutionalized recipients.

2. Long-term Care Personal Needs Allowance \$1,499,649

Monthly personal needs allowances consist of the state's maximum \$30 share of the \$55 monthly payment to recipients in long-term care institutions.

3. Rest Home Vendor Payments \$8,300,000

Payments to rest homes represent the difference between recipients' income, including SSI grants, and the cost of residing in the rest home. FY87 expenditures are adjusted for a projected 4% increase in rest home vendor rates.

4. Emergency Needs \$2,184,000

Emergency needs expenditures include payments for funerals and emergency utility, food and furniture payments. FY87 projected expenditures assume a 4% increase over FY86 expenditures.

FOOD STAMP PROGRAM (4400-1200)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Benefits				
Issued	\$183,000,000	\$171,000,000	\$161,000,000	\$155,000,000
Average				
Caseload	151,789	142,392	138,500	136,425
State				
Expenditures	\$11,143,885	\$11,165,079	\$11,354,636*	\$11,388,861

The Food Stamp Program, created by Congress in 1964, provides benefits to needy families in the form of coupons which can be used as cash to purchase food. These benefits are fully funded by the federal government; the Commonwealth administers the program and pays 50% of all administrative costs.

Food Stamps are an important adjunct to the cash assistance programs administered by the Department. An AFDC family of three with no other income can receive up to \$152 per month in Food Stamps; a GR individual can receive up to \$77 per month. These additional benefits make a substantial difference in the ability of public assistance recipients to adequately feed themselves and their families. Households which do not receive cash assistance such as AFDC, General Relief, or SSI, but which fall within income and asset guidelines may also receive Food Stamps; thus, Food Stamps help the working poor stretch their earnings and remain independent of cash assistance.

During the first five months of FY86, the Department provided assistance to an average of over 138,000 Food Stamp households each month, with federal benefits totalling \$67.1 million, and expected to reach a total of \$161 million by the close of the fiscal year. Of those benefits, 60% will be provided to AFDC households, 10% to GR households, 8% to SSI households, 2% to Refugee Assistance households, and 21% to Non-Public Assistance (NPA) households.

Unlike other federally funded assistance programs such as AFDC and Medicaid, which are overseen by the U.S. Department of Health and Human Services, the Food Stamp Program is overseen by the Food and Nutrition Service of the U.S. Department of Agriculture (USDA). USDA regulations, not the Department, set eligibility, income, and payment standards. States are granted some flexibility in how they choose to administer the program and issue benefits, within USDA's timeliness and accuracy standards.

* Expenditures include \$2.9 million from other operating accounts in FY85 and \$2.7 million in FY86.

Each month, the Department sends Authorization to Participate cards (ATPs) to clients. Clients take these ATPs to one of the 528 issuing locations across the state where they exchange them for actual Food Stamp coupons. The coupons may only be used to purchase groceries or plants and seeds to grow food; they cannot be used to buy prepared food, alcohol, vitamins, pet food or any non-food item. A client purchasing food with Food Stamps may receive a maximum of \$0.99 in cash as change, the rest must be in Food Stamps.

PERFORMANCE 1983 - 1986

The Department has implemented a number of initiatives designed to improve services to those in need and to control administrative costs through effective management.

A. Error Rate Reduction

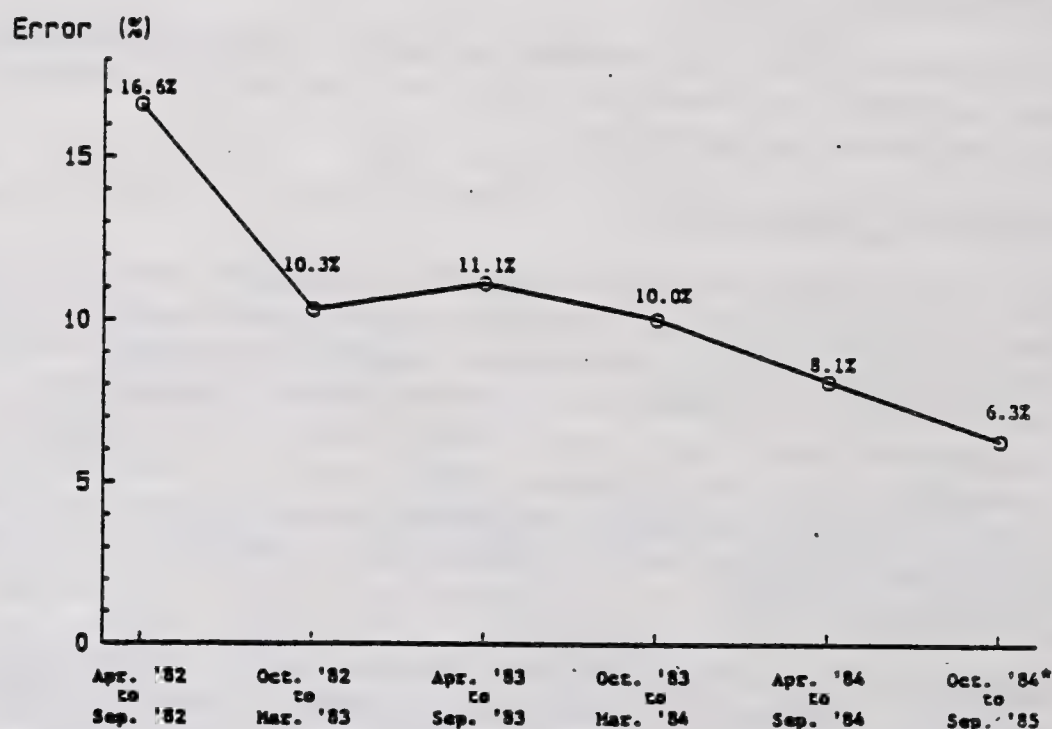
The Food Stamp error rate is defined as the proportion of inappropriate benefits issued compared to the total dollar amount of benefits issued. Inappropriate benefits are overpayments to eligible recipients or payments to ineligible households. The federal government sets an error rate target and sanctions states for exceeding it. The current target is 5%. Sanctions are 5% of the federal portion of administrative costs for each of the first three percentage points above the target, and 10% for each additional percentage point.

Reducing error is a critical administrative priority for a number of reasons, including avoiding potential administrative sanctions, maintaining public confidence in the programs the Department administers, and providing accurate and timely benefits to clients. Between September 1982 and March 1985, the Department's Food Stamp error rate decreased 8.9 percentage points, from 16.6% to 7.7%. The decline is due to a number of initiatives, three of the most important of which were:

- o Local Office Quality Control - This project involves the examination of more than 2,000 cases per month to help eliminate errors before the semi-annual Quality Control reviews which determine the official error rate. The system also serves to educate field staff on the importance of accurate eligibility determinations, and results are made immediately available to local offices.
- o DES Matching - By matching client records with Division of Employment Security records, the Department identifies client failure to report unemployment compensation. The Department also matches against the files of other agencies, most notably the Department of Revenue.

- o Improved Field Staff Training - Special training sessions were conducted concerning those program areas shown to be large sources of error. In addition, a periodic "Error Alert Bulletin" is distributed, communicating the findings of the Department's Error Review Committee to the field.

Food Stamp Error Rate 1982 to 1985



* Error rate sampling conducted on a yearly basis beginning 10/84.

B. Photo Identification Card Project

Massachusetts is the first state to have issued photo identification cards statewide, completing this project in December 1983. During the nine months prior to the photo identification card project, duplicate transactions of the Authorization to Participate card (ATP) totalled as many as 800 cases per month. Approximately \$1.3 million in federal Food Stamp benefits were fraudulently transacted in the 12 month period prior to the photo identification card project. The most common method by which unauthorized ATPs were obtained was large-scale mail theft. Households that were victims of ATP theft were given replacements after their own ATPs were stolen, but the process produced undue hardship, particularly for the most vulnerable populations--women with children, the elderly and the disabled.

Since initial implementation of the photo ID card project in May 1983, duplicate transactions have declined by 75% and systematic mail theft has been eliminated. ATP overutilization has fallen below 160 cases per month, for less than \$16,000 a month in program benefit dollars.

The Department's Finance Division is responsible for implementing changes in the photo identification program, as well as for monitoring ongoing ATP transaction activity.

PHOTO ID CARD PROJECT -- FEWER DUPLICATE ATPs TRANSACTED

Average Monthly Duplicate ATPs Transacted

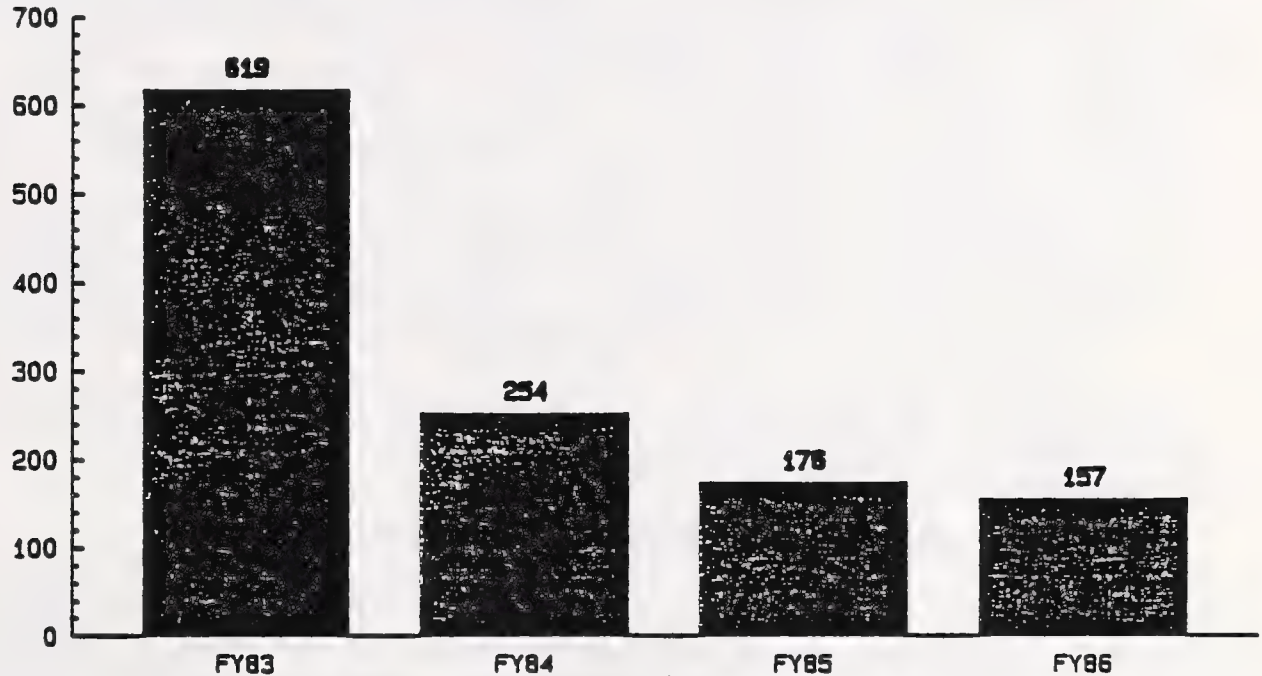


Photo ID project began April 1983.

FY86 average represents 4 months of data.

C. Outreach Programs

Nearly all of the Department's clients are eligible for and should receive Food Stamps, based on their income. Only 82% of AFDC recipients, 79% of GR recipients, 69% of Refugee Assistance recipients, and 28% of SSI recipients actually receive Food Stamps, however. In addition, an unknown number of the poor who do not receive cash assistance are eligible for Food Stamps but are not receiving them.

In response to the critical needs identified in December 1983 by the Department of Public Health's Massachusetts Nutrition Survey, the Massachusetts Legislature approved a supplemental appropriation providing funds for nutrition outreach. The Department began a program to increase Food Stamp participation in May 1984. The program included:

- o awarding grants to 12 community action programs (CAPs) in targeted cities and towns identified in the DPH Nutrition Survey to identify potentially eligible populations in these communities and inform them of the availability of Food Stamps;

- o producing and distributing over 500,000 informational brochures in a variety of languages;
- o airing 136 Public Service Announcements in targeted areas of the state;
- o conducting 25 training sessions for community groups that work with low-income households, organizations for the elderly, and food distribution agencies; and
- o running 150 bi-lingual transit advertisements in Springfield.

During the first three months of this outreach program, the number of Food Stamp applications increased by 16% in the targeted offices but by less than one percent in the non-targeted offices. The caseload increased by 1% in the targeted offices while declining by 7% in the non-targeted offices; the number of applicants in dire need (those with no other income) increased by 13% in the targeted offices but by only 4% in the non-targeted offices.

D. State Supplementation of the WIC Program

The federal Women, Infants, and Children (WIC) program, administered by the Department of Public Health, provides extra food and milk to pregnant women, nursing mothers, and their children under age five. This population is at serious nutritional risk, and the WIC program is one which can have a strong positive impact. Studies have shown that every dollar invested in WIC results in eventual savings of three dollars in hospitalization costs.

WIC, however, is not a priority for the federal government, which has made little or no effort to increase participation in this program. In 1982, Massachusetts enrolled only 20% of eligible families, or a total of 30,000, at a time when a DPH study found that there were an additional 17,000 undernourished children in the state and when the infant mortality rate was rising for the first time in nine years.

Massachusetts became the first state in the nation to supplement the WIC program with state funds, spending \$6 million. An intensive outreach program was conducted, eight new local programs were established, and a special project to increase participation in WIC by Southeast Asians was implemented. As a result of this program, the number of families participating in WIC has more than doubled. The Commonwealth is now serving 65,000 women, infants, and children through 35 local programs at over 100 sites across the Commonwealth with nutritious food, nutrition counseling, and health care referrals.

E. Access to Benefits--Issuing Agent Fee Increases

A critical factor in maintaining Food Stamp recipients' access to benefits is retaining and expanding the number of issuing agents, banks and retail outlets which issue food stamps each month in exchange for the recipient's Authorization to Participate card (ATP).

Issuing agent fee increases of 10 cents per ATP in both FY84 and FY85 have helped to prevent more issuing agents from withdrawing from the Food Stamp Program. There are currently 528 issuing agents statewide.

F. Streamlined Assistance to the Elderly -- SSI Demonstration Project

In 1981, the Department established a demonstration project to reduce barriers to receiving food stamps for certain aged and disabled Supplemental Security Income (SSI) recipients and to lower administrative costs to the state. This demonstration project created a streamlined eligibility determination and review process for those SSI cases unlikely to have material changes in their circumstances. In order to maintain a high standard of accuracy, the expedited process is reserved for "simple" cases: aged or disabled SSI recipients who live alone, are over the age of 18, and have no source of earnings other than the SSI grant.

Due to the uniform income and household information of these cases, Financial Assistance Social Work Technicians can calculate monthly benefit levels and perform regular redeterminations using automated systems rather than manual, labor-intensive systems and without needing to interview the client face-to-face. This allows for a 2,000:1 case to worker ratio, versus the 200:1 ratio maintained by local office workers for other cases. Originally, USDA approved the project on a temporary basis. It continues to waive the face-to-face interview requirement for the Demonstration Unit's cases because the error rate in these cases is low, the process reduces the burdens placed on aged and disabled recipients, and lower staffing costs result in savings to both state and federal taxpayers.

An initial intake of approximately 25,000 "simple" cases took place during October 1981. In September 1984, the Department's System Unit was responsible for identifying all "simple" cases being handled by local office staff and performing a transfer of these 6,000 cases to the SSI Demonstration Unit at the Hawkins Street office. The Department continues to monitor this program on an ongoing basis, including reviewing State Data Exchange (SDX) information for referral of all income-eligible SSI cases to the project. This regular outreach to SSI recipients ensures that those recipients who meet the "simple" case criteria face few barriers to Food Stamp Assistance.

FY87 AGENDA

The Department's agenda in FY87 is to continue to ensure that the Commonwealth's poor receive necessary assistance from the entitlement programs it administers, including Food Stamps, and to control administrative costs without compromising the availability or quality of services.

A. Services to Those in Need

In FY86, the Department will conduct a \$50,000 outreach program, concentrating on increasing the participation of pregnant women, young mothers, and the elderly, groups at great nutritional risk. The Department plans to lease video equipment and produce outreach videotapes to be shown in local offices and at outside locations such as senior citizen's centers. The video format has great advantages in reaching the target groups. For those with poor language skills printed materials alone may be of limited value. Many of the elderly have poor eyesight for close work which makes reading difficult, a problem which is overcome by presentation of information on videotape.

The Department has requested \$66,000 in FY87 to continue this program, including translating the previously produced material into Spanish.

B. Improved Management

o Error Rate Reduction

The Department plans to continue to make progress in maintaining and lowering the Food Stamp error rate. Current training and systems matching programs will be continued and expanded, with special emphasis on clarification of federal policy on household composition. In addition, a matching program with the Social Security Administration will be implemented as part of the implementation of the new MPACS computer system, scheduled for statewide implementation in FY87.

o Better Service Delivery

With MPACS, a new case management model will be introduced in the Department's local offices. This model will alter the way in which work is currently performed and will enable the Department to increase the quality of service to clients. Under this method of field staffing, one social worker will determine a client's eligibility for all the various assistance programs administered by the Department, including AFDC, Medicaid, and Food Stamps. More detail on the design of this new staffing model and its benefits is provided in the description of Local Office Operations elsewhere in this volume.

The implementation of this method of staffing will result in improved coordination of the various programs, providing better services to clients. As a first step in its implementation, Financial Assistance Social Work Technicians (FASWTs) who administer the Food Stamp program will require upgrading and training to assume the tasks of an integrated eligibility worker. The upgrading will result in the FASWTs assuming responsibility for cash assistance and medical assistance programs.

PROGRAM ELIGIBILITY AND BENEFITS

The Food Stamp program provides assistance to individuals and families that meet the financial standards set for the Food Stamp program by USDA. Anyone who is income-eligible can participate, as there are no substantial categorical requirements. USDA monitors the state's accuracy and timeliness in determining eligibility and delivering benefits. States are permitted some flexibility in their methods of delivering the benefits, but program eligibility requirements are standardized nationwide.

Financial eligibility consists of three components: assets, gross income, and net income. The household's assets and gross income must fall below certain ceilings. Net income is then determined by subtracting a variety of deductions, and is used to determine the number of Food Stamps a family will receive.

A. Assets

Households must pass an asset test in order to participate in the Food Stamp program. Assets include cash on hand, money in checking or savings accounts, other investments, land, buildings, vehicles, and property not easily converted to cash. The limit for a household's assets is \$1,500, or \$3,000 for households with two or more members if one member is age 60 or over.

B. Gross Income

After passing the asset test, recipients must also pass a gross income test. The gross income ceiling applies to all households seeking Food Stamps, except households that have an elderly or disabled member. Households with an elderly or disabled member are only subject to a net income test. Income includes wages, self-employment earnings, public assistance grants, pensions, child support, and alimony.

<u>MONTHLY GROSS INCOME CEILINGS BY FAMILY SIZE</u>	
<u>Household Size</u>	<u>Maximum Allowable Monthly Gross Income</u>
1	\$ 569
2	764
3	959
4	1,154
5	1,349

C. Net Income

If a household's gross monthly income does not exceed the ceiling and its assets are not over the asset limit, a final income test is

applied. All households must meet this net income test. Income for households containing elderly or disabled individuals is only subject to this income limit and not the gross income limit. Net income consists of gross income minus the following four deductions:

- o an earned income deduction of 18% of gross earnings.
- o a standard deduction of \$98 for all households.
- o a dependent care, excess shelter cost, and utility cost deduction of up to a maximum of \$139. For households with an elderly or disabled member, there is no limit on the deduction for shelter and utility expenses.
- o a medical deduction of monthly costs above \$35 for recipients who are aged or disabled and receiving SSI or veterans' benefits.

<u>MONTHLY NET INCOME CEILINGS BY FAMILY SIZE</u>	
<u>Household Size</u>	<u>Maximum Allowable Monthly Net Income</u>
1	\$ 438
2	588
3	738
4	888
5	1,038

D. Calculating the Food Stamp Benefit

A family's Food Stamp allotment depends on the family's net income and the number of persons in the household. Maximum benefits are received by households with no net income. As net income increases by approximately \$10, the allotment level decreases by approximately \$3, or 30%. The maximum allotments that eligible households can receive in a month are presented in the following chart:

<u>MAXIMUM ALLOTMENTS BY FAMILY SIZE</u>	
<u>Household Size</u>	<u>Maximum Coupon Allotment</u>
1	\$ 80
2	147
3	211
4	268
5	318

E. Adequacy of Food Stamp Benefits

USDA is required by the Food Stamp Act of 1977 to take changes in the cost of living into account in setting benefit levels. Annual adjustments in maximum allotments or in the standard shelter, dependent care and utility deductions are made that reflect changes in the Consumer Price Index for all Urban Consumers (CPI-U). Even so, increases in maximum allotments have lagged behind inflation. Maximum allotments have increased 41% since FY80, while inflation has totaled 49%.

<u>ALLOTMENT INCREASES V. INFLATION</u>			
	Maximum Allotment <u>Family Size 3</u>	Percent Increase in Allotment	<u>Inflation</u>
FY80	\$161	7.3%	12.0%
FY81	183	13.7%	7.2%
FY82	183	0.0%	4.7%
FY83	199	8.7%	3.8%
FY84	199	0.0%	5.1%
FY85	208	4.5%	5.3%
FY86	211	1.4%	3.4%
		—	—
	Cumulative Increase	40.7%	49.0%

There is a more fundamental inadequacy with Food Stamp allotment levels, however. Food Stamp allotment levels are based on the USDA's Thrifty Food Plan. This plan, which was originally developed in 1955, was not specifically designed to meet long-term nutritional needs, and thus understates the amount of food actually needed. It is designed to describe the minimum short-term nutritional needs of a family of two adults and two children aged 6 to 8 and 9 to 11, not typical of Food Stamp families. In addition, USDA's estimate of the cost of purchasing the Thrifty Food Plan fails to take into account the higher prices often charged by food retailers in poor neighborhoods.

A family of three receiving the maximum AFDC grant of \$432 in FY86 will receive a Food Stamp allotment of \$152, which requires budgeting only \$1.69 per person per day, or 56 cents per meal. Clearly, this level of assistance will only supplement and not support an adequate diet. The adequacy of Food Stamp benefits is especially critical for two reasons: the large number of children whose nutritional needs must be met with Food Stamps, and the low number of participants in the program with income other than a public assistance grant.

Families often run out of coupons before the end of the month and are forced to rely on unpredictable and irregular crisis assistance from

food banks and soup kitchens, a particular hardship for families with children or elderly members. Further, because Food Stamp allotment levels decrease as net income increases, each time the Commonwealth raises AFDC or GR payment levels, this increased income actually results in a decreased Food Stamp allotment, with the result that AFDC households receive Food Stamp allotments nearly 40% below the maximum level.

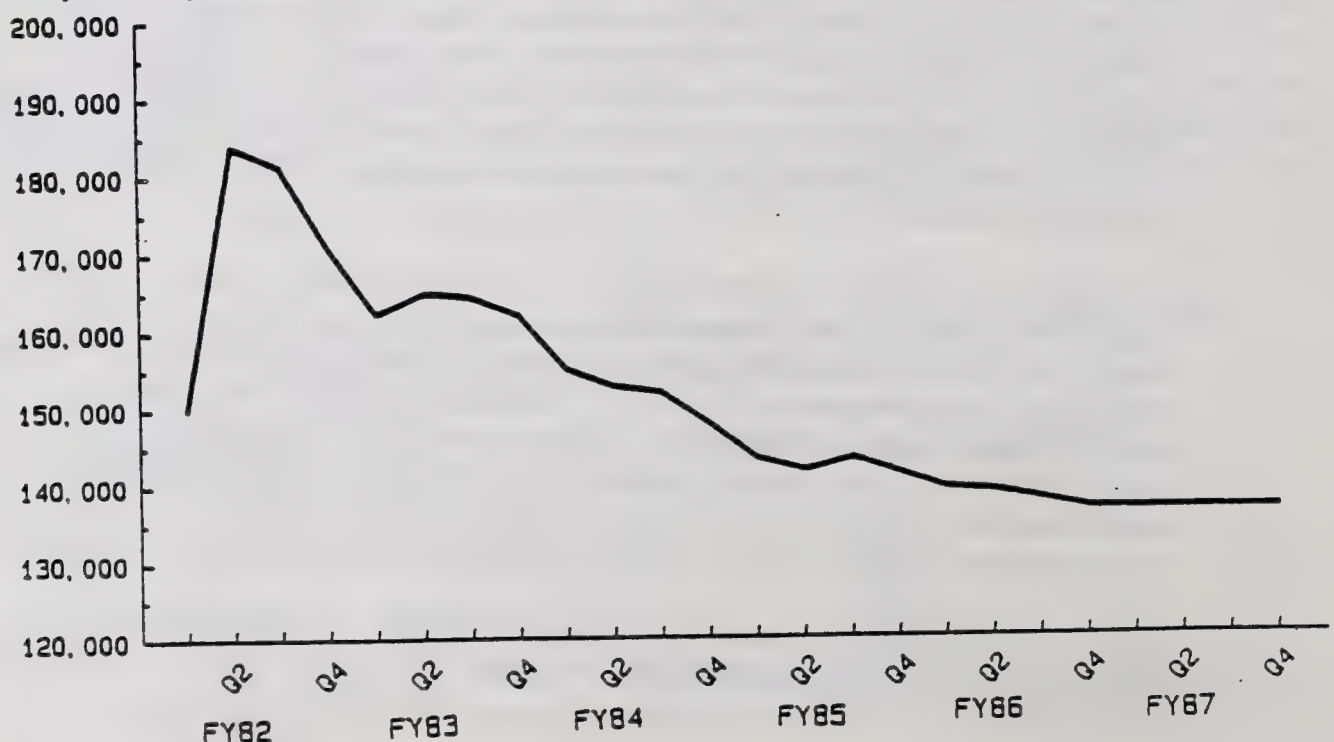
DEMOGRAPHICS AND CASELOAD

In FY85, the Department provided Food Stamps to an average of 142,392 households each month. In FY86, the average monthly caseload for the first five months was 139,095. This declining caseload reflects declining public assistance caseloads, combined with a strong Massachusetts economy. An analysis of Food Stamp caseloads over the last three years and caseload projections for FY86 and FY87 predict a continued decline in the number of households participating in the Food Stamp program, albeit at a slower rate in FY86 and FY87. As a result, fewer administrative resources will be needed. However, it should be noted that, historically, fluctuations in the NPA Food Stamp caseload have been difficult to anticipate, due to the lack of data available on these households.

87% of Food Stamp households also receive another form of public assistance. 51% receive AFDC, 14% receive GR, 21% receive SSI, and 1% receive Refugee Assistance. The remaining 13% of the Food Stamp caseload consists of households which do not receive any other form of public assistance.

FOOD STAMP CASELOAD FY82 - FY87

Quarterly Average Caseload



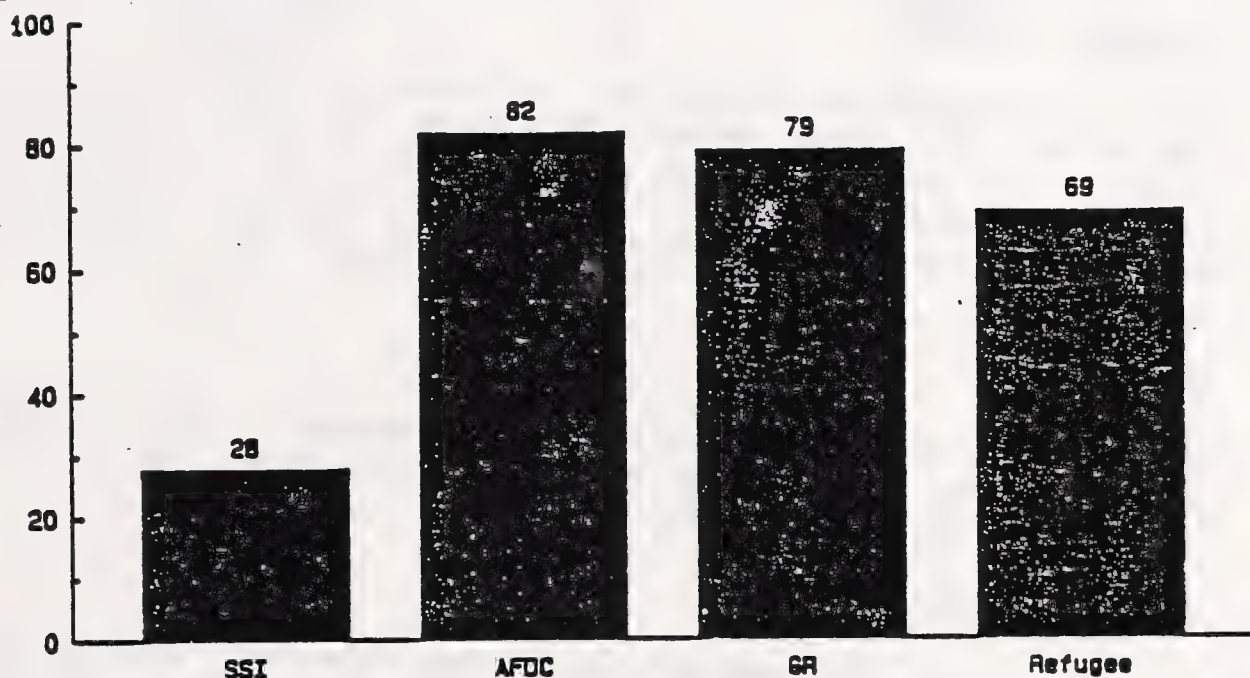
FY86 Q3-4, FY87 are projected.

A. Participation in the Food Stamp Program

On average, only 55% of public assistance households receive Food Stamps. Participation among recipients of AFDC, GR, and Refugee Assistance averages 81%, but the overall average is much lower due to a participation rate of only 28% among SSI recipients. Participation rates by category of assistance are indicated below:

FY86 FOOD STAMP PARTICIPATION RATES

Percentage of Caseload Receiving Food Stamps



The failure of the large majority of SSI recipients to participate in the Food Stamp program is mainly due to the low allotment levels for which they are eligible. Most SSI recipients are eligible to receive less than \$30 a month in Food Stamps, and many would receive only \$10. Not surprisingly, many elderly or disabled people feel that such a small benefit is not worth the effort involved in obtaining and using Food Stamps.

Participation rates are much higher among recipients of other forms of cash assistance, but some eligible people still fail to participate. Refugees may experience language barriers. Other clients may wish to avoid the stigma often attached to those seen making purchases with Food Stamps.

B. Sex

Most Food Stamp households are headed by women--over 81%. AFDC and SSI Food Stamp households are most commonly headed by women, with 96% and 82%, respectively. Both GR and Refugee households are more likely to be headed by a man than by a woman. However, because 72% of the Food Stamp caseload is made up of AFDC and SSI households, there are more female-headed households overall.

C. Race

Like recipients of cash assistance, most Food Stamp recipients are white: 62% are white, 16% are black, and 19% are Hispanic, with the remaining 3% being Asian or Native American.

D. Children

There are approximately 130,000 children in Food Stamp households. 49% of all Food Stamp households contain children. This percentage reflects the fact that there are children in all AFDC households and in many households that do not receive other forms of public assistance, but very few children in GR and SSI Food Stamp households.

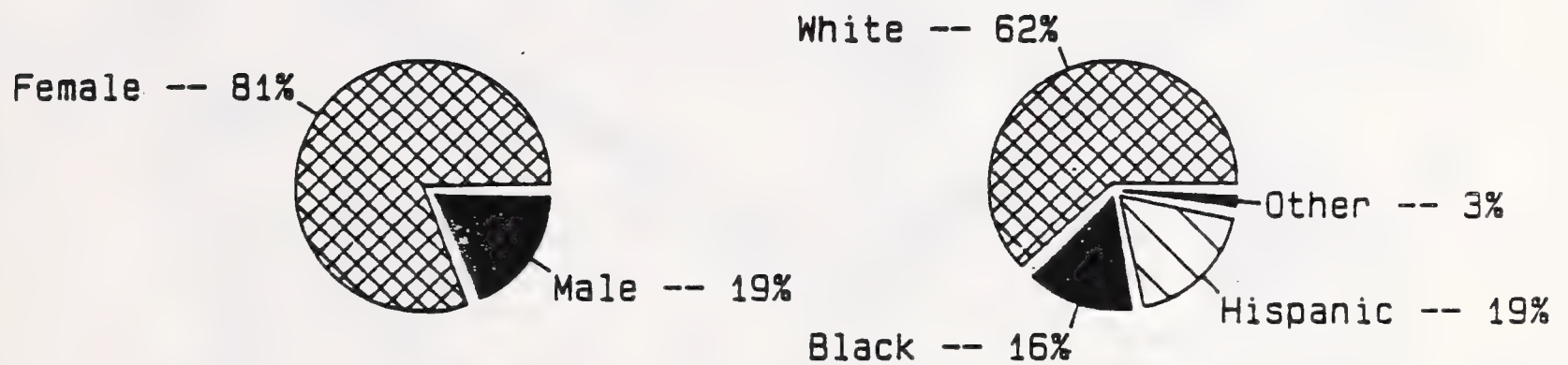
E. Homelessness

Homelessness does not disqualify an individual or family from program participation. No mailing address is necessary; the recipient can pick up the ATP at the local office.

F. Geographic Area

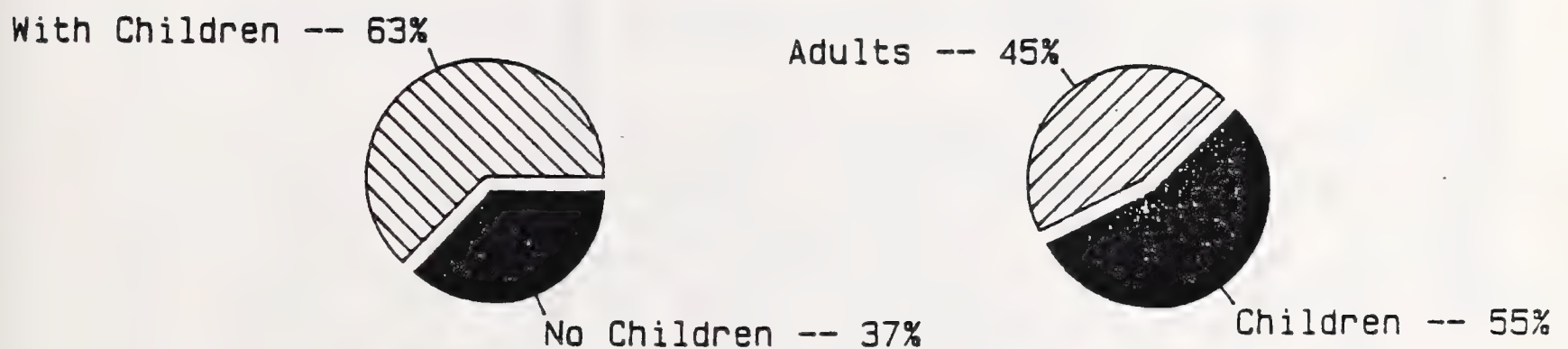
The Food Stamp caseload is distributed relatively evenly across the state. Approximately 20% of the households are in Boston and 11% in greater Boston.

FY86 FOOD STAMP PROGRAM CASELOAD CHARACTERISTICS



SEX OF HEAD OF HOUSEHOLD

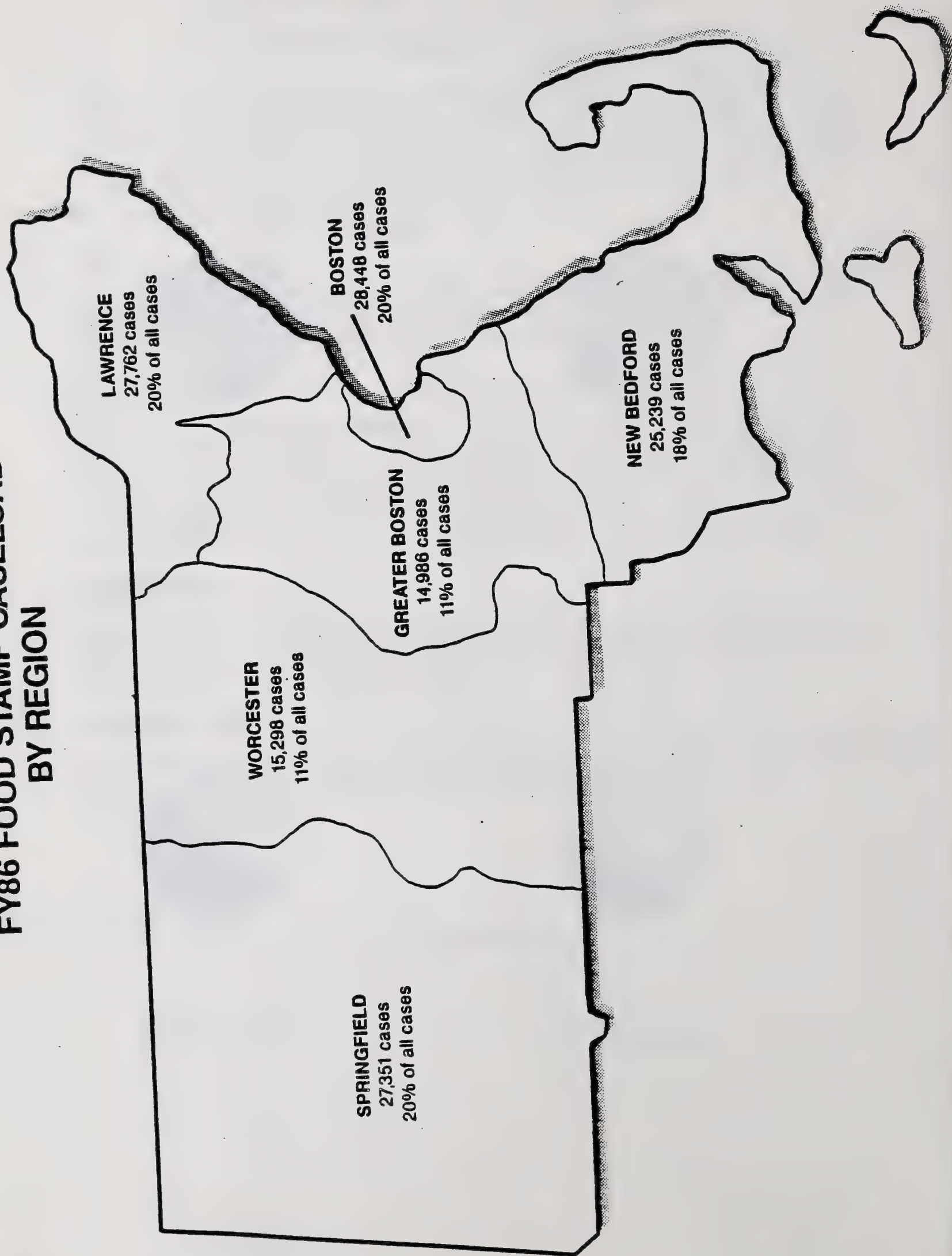
RACE



HOUSEHOLDS

RECIPIENTS

FY86 FOOD STAMP CASELOAD BY REGION



ADMINISTRATION OF THE FOOD STAMP PROGRAM

In FY87, the Food Stamp account will fund the cost of administering benefits to approximately 136,425 households, consisting of 325,000 individuals. The federal government grants states relative autonomy in developing the method by which benefits will be delivered to recipients. In Massachusetts, the Department has made efforts, including the SSI Demonstration Unit and photo identification card projects, to ensure expedient issuance, while improving accountability and reducing fraud. Estimated expenditures of \$11.4 million in FY87 include the cost of personnel, travel and postage, as well as fiscal and issuing agent fees.

A. Components of Expenditures

The federal government funds 100% of Food Stamp benefit costs and 50% of administrative costs. The state expenditures of \$11.4 million reflect total administrative costs, 50% of which are reimbursed by the federal government.

Approximately 70% of the \$11.4 million is for the cost of personnel, primarily for field staff who provide direct service to recipients. Currently, these personnel are only responsible for processing Non-Public Assistance Food Stamp cases, i.e., those Food Stamp households not receiving cash assistance. Public Assistance Food Stamp households are certified for Food Stamps and cash assistance simultaneously by Financial Assistance Social Workers, who are funded out of the Local Office account (4400-0900). As part of the implementation of MPACS and improved case management in FY87, the Department is requesting that Food Stamp field staff be upgraded to Financial Assistance Social Workers so that they may determine client eligibility for all programs, not just Food Stamps.

The remaining 30% of expenditures fund fiscal and issuing agent fees, postage and supplies, and outreach.

The Department contracts with fiscal and issuing agents, such as banks, who are responsible for data processing, transacting ATPs, and tracking Food Stamp issuances. In FY86, Massachusetts had one of the lowest payment costs per ATP, among states with comparable issuance systems. This low rate, compared with other states', held true even after a February 1985 issuing agent fee increase of 10 cents per transaction. Continued funding of adequate personnel levels, postage, and fiscal and issuing agent fees is essential, given the integral functions each performs in the Food Stamp program's benefit delivery system.

B. The Delivery System

The initial step in receiving Food Stamp benefits is an application at the local office. Unless the applicant is unable to go to the welfare office because of age, handicap, or hardship, a personal interview is required with a eligibility worker. An "authorized representative," who may be a friend, relative, or anyone to whom the applicant gives written permission and who is familiar with the

household's situation, can go to the interview in place of the applicant. An application is taken by a direct service worker and eligibility is determined as soon as necessary verifications are received.

Once eligibility has been determined and benefit levels have been calculated, the recipient is notified of the next mailing date of Authorization to Participate cards (ATPs). ATPs are mailed once each month, with the date determined by the last digit of the recipient's Social Security number. Households with no net income or less than \$150 in gross income are eligible for expedited issuance, and will receive an ATP within five days of the date of application. Applicants in dire need are eligible to receive ATPs at the application interview. ATPs are then automatically issued each month to the recipient's address, or to the local office if no mailing address is available.

Once received, the ATP is exchanged at an issuing agent site, which may be one of over 500 banks and retail outlets statewide, for Food Stamp coupons in the amount indicated on the ATP. The agent is responsible for verifying identity with the client's photo identification card. The last step in the Food Stamp system is the purchase of food with coupons at hundreds of stores statewide.

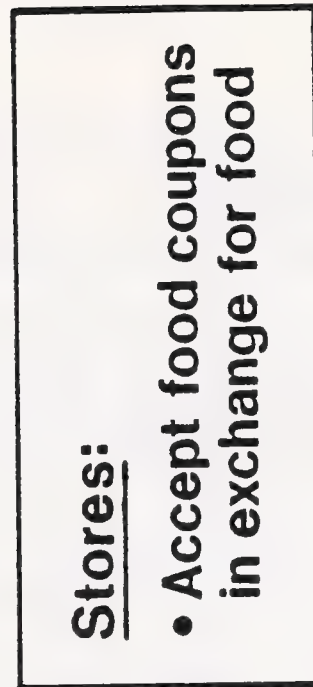
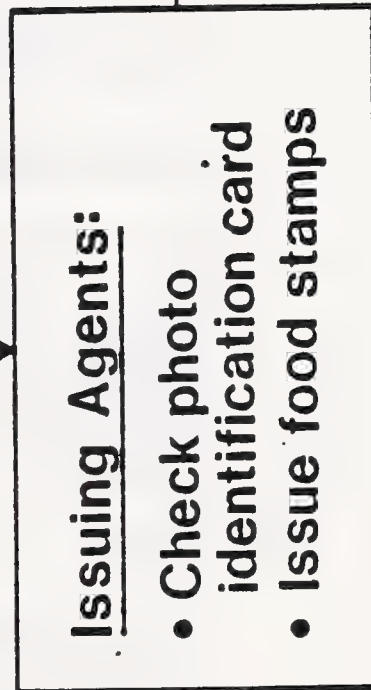
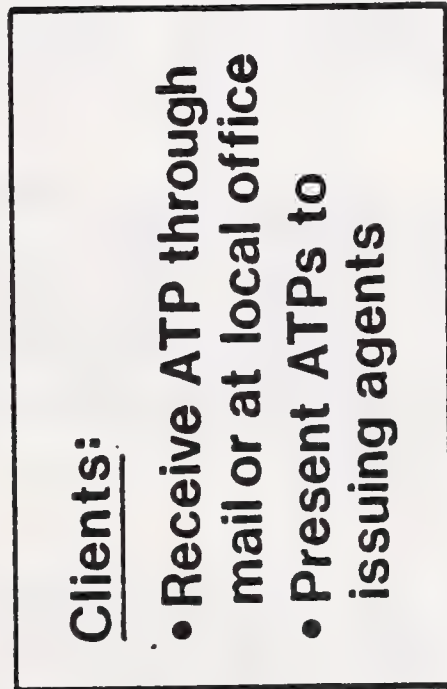
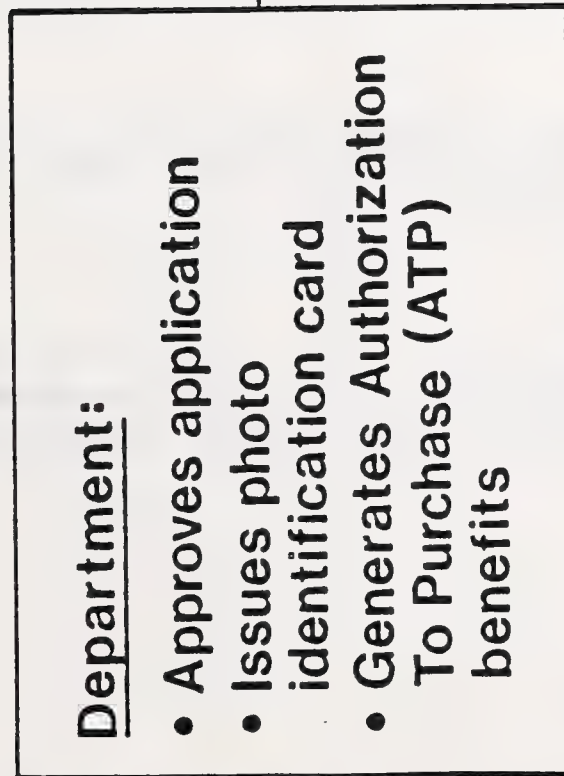
The following chart outlines the benefit issuance system.

FOOD STAMP BENEFIT ISSUANCE SYSTEM

Eligibility Determination

Issuance

Transaction



FY87 REQUEST

1. Personnel (01, 02)	\$7,838,833
2. Fiscal Agent	3,057,469
3. Travel	25,127
4. Postage	400,000
5. Outreach	<u>66,432</u>
TOTAL REQUEST	\$11,388,861

1. Personnel \$7,838,833

The personnel subsidiaries fund the cost of 373 Food Stamp program staff. Approximately 75% of this number are Financial Assistance Social Work Technicians who are responsible for intake and eligibility redetermination functions in local offices. The remaining 25% include clerks and supervisors.

2. Fiscal Agent \$3,057,469

This item will fund the continuing contract with the Department's Food Stamp Fiscal Agent, funded in the Contract Operations Account (4400-0900) in FY86. The Fiscal Agent provides fiscal responsibility for the Food Stamp program by accounting for each Authorization to Participate (ATP) card issued each month, maintaining records of all transactions and disbursing checks to individual Issuing Agents.

3. Travel \$ 25,127

It is estimated that each of the Department's six Food Stamp auditors will travel 1,325 miles per month between 53 local offices and over 500 issuing agents' sites, as required by USDA. These auditors ensure prompt and accurate services, as well as monitoring the appropriate issuance of ATPs. Failure of the auditors to make these visits would result in USDA sanctions.

4. Postage \$ 400,000

This funding includes the cost of mailing approximately 136,500 Authorization to Participate cards every month, as well as recipient notifications.

5. Outreach \$ 66,432

This item will fund continuing efforts to increase the participation of underserved low-income populations in the Food Stamp program, continuing the program begun in FY86.

INTRODUCTION TO SPECIAL PROGRAMS FOR THE HOMELESS AND REFUGEES

While all of the low-income families and individuals the Department serves are needy, two populations, refugees and homeless families and individuals, are in particular need of the cash, medical, shelter and social services the Department provides. For refugees, many of whom have fled religious, race or other persecution in their native lands, resettlement in the United States and economic self-sufficiency are made possible in part by the English as a Second Language, education, employment and social services the Department provides. The homeless are among the most vulnerable populations in the Commonwealth. The state-wide system of shelters funded by the Department, up from 2 shelters funded by the Department in FY82 to 51 in FY86, with funds requested for 61 in FY87, is a critical support system for these families and individuals. Adequate low-income housing, health services and income are critical to poor families' ability to support their children on an ongoing basis in permanent housing.

The following two sections describe the Commonwealth's programs for each of these two groups:

- o Homeless Assistance (4406-3000)
- o Refugee Assistance (4409-3000)

ASSISTANCE TO THE HOMELESS (4406-3000)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Number of Shelters	15**	37	51	61
Number of beds	907**	1,422	1,699	1,950
Total Expenditures*	\$3,531,593**	\$4,813,000	\$10,900,000	\$12,305,000

The homeless, with minimal financial resources, few if any family and community ties, and continual danger from cold, hunger, and disease, are perhaps the most vulnerable residents of the Commonwealth. Survival for this population is often a day to day struggle. Further, the homeless population, traditionally made up of individuals, now also includes a significant number of families and young children. Extremely low vacancy rates (less than 1% in some Massachusetts cities), soaring rents, and the removal of rental housing from the market through condominium conversions are forcing both public assistance recipients and the working poor out of the private housing market. Public housing is scarce; only 25 to 30% of families on public assistance in Massachusetts live in public housing and waiting lists can total years. The loss of a job, an expensive medical emergency, or the sale of an apartment building can force a family out of its home.

A Homelessness Services account was established by the legislature in FY85 in response to the growing problem of homelessness. Services funded from this account include emergency shelter, clothing, food, case management, and housing services for homeless individuals and families. In addition to addressing clients' immediate needs, the Department, the administration, and the legislature are acting to increase the availability of affordable housing and thus obtain more long-term solutions to the specific problems confronting the homeless population.

*This program was funded from the General Relief account (4406-2000) prior to FY85. Totals include expenditures from GR of \$0.5 million in FY85 and an estimated \$3.5 million in FY86.

**In addition, 25 temporary shelters received \$1.3 million in Federal Emergency Management funds.

The services provided in FY86 by the Department include:

- o A statewide network of 51 permanent and temporary shelters for families and individuals,
- o Day rehabilitation programs in Boston and Salem, which provide homeless individuals with meals, counseling, social service referrals, and a place to stay during the day. The Boston program serves over 200 persons a day.
- o Family support services in 22 family shelters, providing training in parenting and household management, and counseling for parents and children of almost 200 families at any one time.
- o Housing search and placement services for families residing in hotels and motels, provided in cooperation with the Department of Social Services (DSS). To date these services have helped 600 families locate permanent housing.
- o A cooperative program with the Executive Office of Communities and Development (EOCD) to provide 250 Chapter 707 rental subsidy certificates to families in hotels, motels, and shelters.
- o Homelessness prevention programs, including family stabilization through DSS social workers and landlord/tenant mediation through EOCD's Housing Services program.
- o Direct health services targeted to Boston's homeless population, and outreach and advocacy to help this vulnerable population receive necessary health care services. As of mid-September 1985, 444 homeless individuals had received direct health services through this program, and over 4,500 individuals are expected to receive outreach and advocacy services by the end of the program's first year of operation.

PERFORMANCE 1983 - 1986

In the last three fiscal years, the administration's response to the varying and complex causes of homelessness and the shelter needs of the homeless population has expanded significantly. Many state agencies are assuming an active role in assisting the homeless. The Departments of Mental Health, Social Services, and Public Health, and the Executive Office of Communities and Development have developed and expanded programs for the mentally ill, families in crisis, and alcoholics, as well as programs to develop long-term housing options. The Administration has established a homeless program with seven basic components that range from crisis management to long-term preventive measures, including:

- o Permanent shelters;
- o Temporary shelter grants to community organizations;
- o The Emergency Assistance program;
- o Housing search and placement services;

- o Homelessness prevention;
- o Homeless health services; and
- o Permanent housing.

Each of these components is described below.

A. Permanent Shelters

In FY82, the Department funded only two homeless shelters, the Pine Street Inn in Boston and Shelter, Inc. in Cambridge. The Department, working in conjunction with the Coalition for the Homeless, developed a model for small family shelters emphasizing housing assistance and strong coordination with existing community social service agencies. By the end of FY86, the Department will fund a total of 51 shelters, including 29 permanent shelters, 21 for families and 8 for individuals, in addition to partial funding for the city of Boston's Long Island Shelter, for a total of 1,332 beds.

Through ongoing technical assistance (including budget management, training, and fund-raising workshops) and a close working partnership with the Permanent Charities Foundation's Fund for the Homeless, the Department has been able not only to increase the number of Department-funded shelters statewide but to maintain and strengthen the management of its existing shelters. The Department funds a substantial portion of shelters' operating costs -- between 50 and 75%, depending on the resources available to each shelter in its community.

An estimated 80% of all shelter guests, both individuals and families, receive public assistance. Ninety percent of all families in shelters are single-parent, female-headed households. These families occupy up to one-third of all beds in Department-funded shelters, and stay an average of fifty days. Sixty-five percent of the children in homeless families are under eight years of age.

Services provided at shelters include:

- o Shelter
- o At least two meals a day
- o Housing counseling
- o Family support services
- o Day care
- o Referral to social services agencies

The Department has also implemented programs to meet the special needs of two segments of the homeless population: families and individual women.

o Family Support Services

In addition to the problem of inadequate income, many homeless families face additional problems which are not purely economic in nature. Some heads of households lack the skills or the emotional preparation necessary to maintain a home; many of the

children have behavioral problems resulting from the trauma of homelessness. A recent study indicated that up to 85 percent of homeless families are not ready to live independently.

To help meet the needs of these families, the Department began funding family support services programs at family shelters in FY86. These programs provide counseling to parents and children, help in developing parenting skills, and instruction in necessary survival skills such as budgeting and meal planning. These services will help homeless families make a successful transition to permanent housing and give them the skills to maintain their families intact in permanent housing.

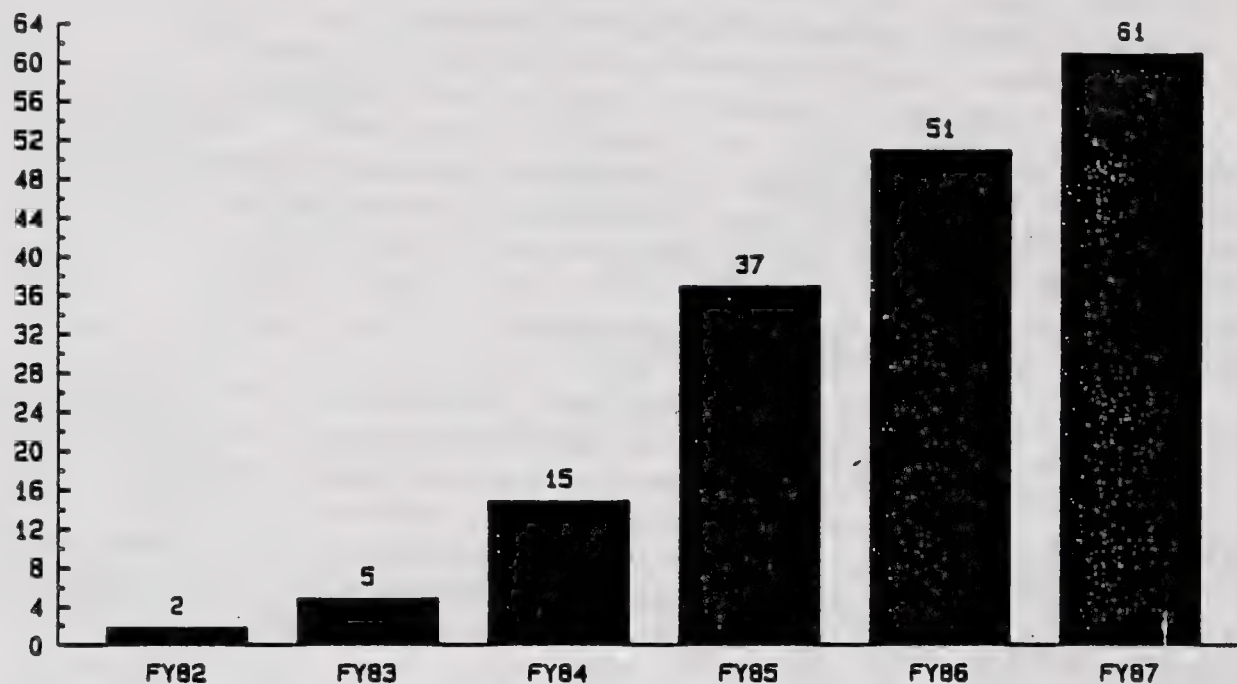
o Shelters for Single Homeless Women

While the majority of homeless individuals are male, studies estimate that women constitute 20-25% of this population. These women often suffer from severe psychological problems, in part because of the traumatic experiences endured by women living on the streets, including sexual assault. While individual shelters such as Long Island and the Pine Street Inn provide facilities for women, many of these women distrust and fear the large shelters.

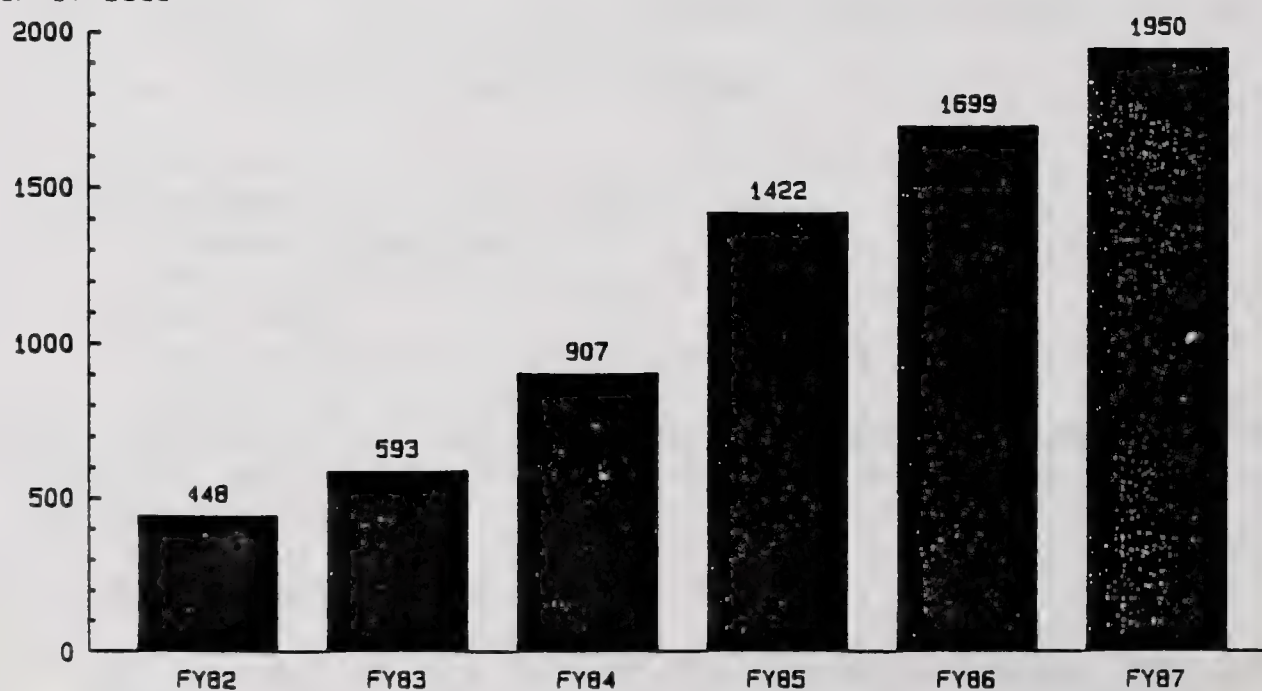
In FY86, the Department will be funding a new, 50-bed shelter for individual women in Boston. This facility will be operated by the Pine Street Inn, but at a location separate from its large, 350-bed shelter. It will provide a safe, more supportive environment for this very troubled population.

DEPARTMENT-FUNDED HOMELESS SHELTERS FY82 - FY87

Number of Shelters



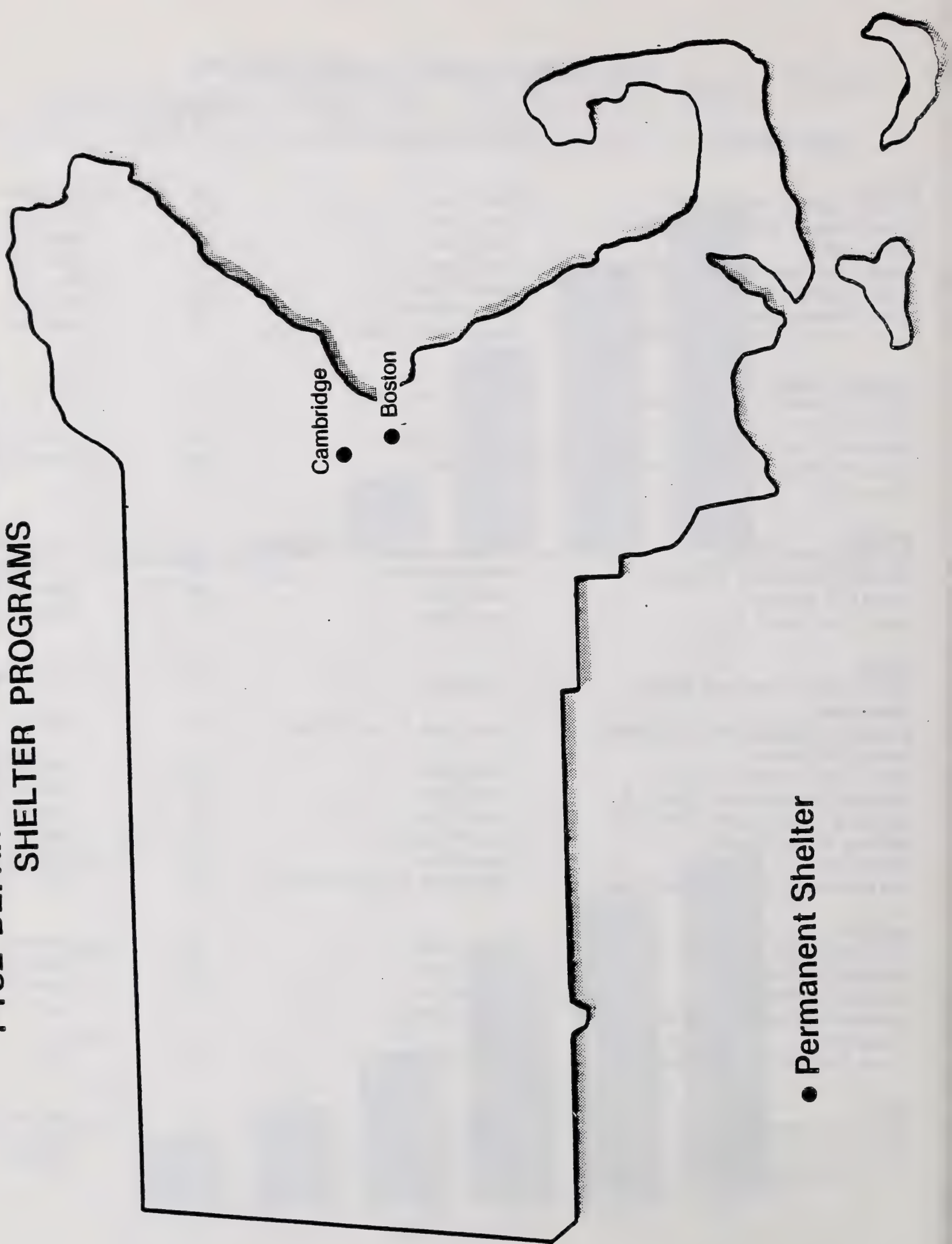
Number of Beds



FY86 DEPARTMENT-FUNDED PERMANENT SHELTERS

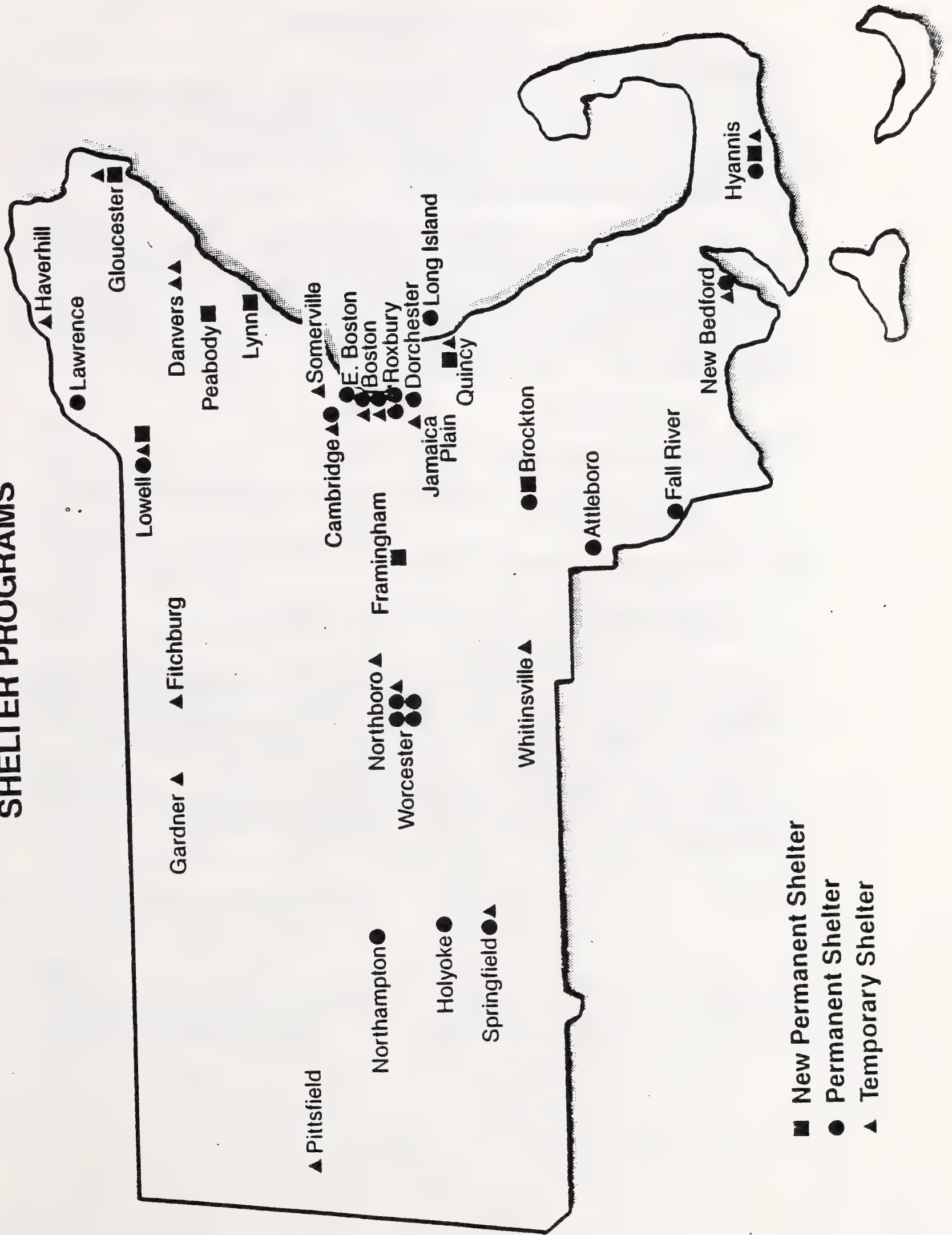
<u>Area/Shelter</u>	<u>Population Served</u>	<u>Number of Beds</u>	<u>Location</u>
<u>Boston</u>			
Boston Family Shelter	Families	35	Boston
Cape Verdean Community House	Families	33	Roxbury
Crossroads	Families	35	East Boston
Little Sisters of the Assumption	Families	20	Dorchester
Long Island Shelter	Individuals	216	Boston
Pine Street Inn	Individuals	400	Boston
Roxbury Multi-Service Center	Families & Individuals	35	Roxbury
<u>Greater Boston</u>			
Quincy Interfaith Shelter Coalition	Individuals	25	Quincy
Shelter, Inc.	Individuals	20	Cambridge
South Middlesex Opportunity Council	Families	25	Framingham
<u>Central</u>			
Montachusett Corps	Families & Individuals	28	Leominster
Public Inebriate Program	Individuals	20	Worcester
Youville House I	Families	20	Worcester
Youville House II	Families	20	Worcester
<u>South</u>			
Attleboro Youth and Family Services	Families	27	Attleboro
Brockton Coalition for Young Adult Parents	Families & Individuals	50	Brockton
David Jon Louison, Inc.	Families	25	Brockton
Housing Assistance Corp. I	Families	20	Hyannis
Housing Assistance Corp. II	Families	25	Hyannis
Market Ministries	Individuals	20	New Bedford
NUVA, Inc.	Families	20	Gloucester
Residential Care Consortium	Families & Individuals	25	Fall River
<u>North</u>			
Citizens for Adequate Housing	Families	20	Peabody
Community Teamwork I	Families	20	Lowell
Community Teamwork II	Families	20	Lowell
Greater Lawrence Psychological Center	Individuals	30	Lawrence
Lynn Shelter Association	Individuals	20	Lynn
<u>West</u>			
Jessie's House	Families	20	Northampton
Service Providers	Families	20	Springfield
Valley Opportunity Council	Families & Individuals	28	Holyoke

**FY82 DEPARTMENT OF PUBLIC WELFARE
SHELTER PROGRAMS**



● Permanent Shelter

FY86 DEPARTMENT OF PUBLIC WELFARE SHELTER PROGRAMS



- New Permanent Shelter
- Permanent Shelter
- ▲ Temporary Shelter

B. Temporary Shelter Programs

During the winter, the risk of becoming homeless becomes more acute. Utility costs increase greatly, straining the budgets of low-income families and individuals. Apartments may become uninhabitable due to poor insulation or lack of heating. In the winter, even temporary lack of shelter becomes unendurable.

The temporary shelter program was established in FY84 in response to winter shelter needs in areas of the Commonwealth where establishing a permanent shelter was not the best solution. While permanent shelters operate year-round, the temporary shelter program operates only in the winter months. Grants from this program fund both temporary, community-based shelters and a variety of alternative program services. These include:

- o Case management;
- o Housing search support and referral;
- o Transportation to and from shelters and welfare offices and in housing search;
- o Emergency vouchers; and
- o Homelessness prevention through payment of rental, mortgage and fuel arrearages.

In FY84, the Department spent \$0.2 million on temporary shelter awards, which were for three months only; the federal government provided an additional \$1.3 million in Federal Emergency Management Assistance (FEMA) funds. In FY85, the program was expanded to six months, and the Department spent \$0.5 million to fund 22 programs. In FY86, the temporary shelter program will fund 26 programs at a cost of \$0.8 million; these awards will support over 350 beds and the provision of other services to almost 500 persons.

TEMPORARY SHELTER PROGRAMS**November-May 1986**

<u>Area/Organization</u>	<u>Services Provided</u>	<u>Location</u>
<u>Boston</u>		
Catholic Charities	Shelter	South Boston
F.I.N.E.X. House	Shelter	Jamaica Plain
Mass. Coalition for the Homeless	Donation Assistance	Dorchester
Project PLACE	Day Program	Boston
Salvation Army	Shelter	Roxbury
<u>Greater Boston</u>		
Phillips Brooks House	Shelter	Cambridge
Quincy Crisis Center	Shelter	Quincy
The Somerville Corporation	Shelter	Somerville
<u>North</u>		
Action, Inc.	Shelter	Gloucester
Community Action, Inc.	Shelter, Vouchers	Haverhill
House of Hope	Shelter	Lowell
North Shore Council on Alcoholism	Shelter	Danvers
North Shore Shelter Committee	Shelter	Danvers
Turning Point, Inc.	Vouchers	Newburyport
<u>South</u>		
Housing Assistance Corp.	Shelter, Transportation	Hyannis
South Shore Community Action Council	Vouchers	Plymouth
Volunteers of America	Shelter	New Bedford
<u>Central</u>		
Alternatives Unlimited	Shelter	Whitinsville
Bridge of Central Massachusetts	Shelter	Marlboro
Friendly House	Shelter	Worcester
Gardner Community Action Committee	Shelter	Gardner
Montachusett Opportunity Council	Vouchers	Fitchburg
Our Father's House	Shelter	Fitchburg
<u>West</u>		
City of Springfield	Shelter	Springfield
Franklin Community Action Corp.	Vouchers	Greenfield
Pittsfield Salvation Army	Shelter, Vouchers	Pittsfield

C. Emergency Assistance

Emergency Assistance, or EA, is a program funded from the AFDC account which provides assistance to eligible families with children, in order to respond to a particular emergency. In addition, on January 1, 1985, EA became available to General Relief recipients.

EA benefits help families who are homeless or in danger of becoming homeless. They include:

- o Emergency shelter for up to ninety days
- o Advance rent and security deposit
- o Payment of up to four months' rental and utility arrearages
- o Moving expenses and furniture storage
- o Money to replace food, clothing, and furniture
- o Repair or replacement of essential appliances

Homelessness qualifies families for services under Emergency Assistance. EA is used both to respond to crises and to prevent them.

o Expanded EA Benefits Under Chapter 450 of the Acts of 1983

Chapter 450 extended the Department's ability to use the Emergency Assistance program to prevent homelessness from occurring. It also extended cash and medical benefits to particularly vulnerable populations, including the homeless population and low-income pregnant women.

Specific Chapter 450 provisions include:

- extending from thirty to ninety days the length of time for which emergency shelter services can be authorized;
- removing caps on the amount of Emergency Assistance paid for fuel, utility, rent, and mortgage arrearages, advance rent, and security deposits;
- extending EA benefits to pregnant women in the first two trimesters of pregnancy with no other dependents; and
- providing General Relief benefits to otherwise eligible homeless applicants without a permanent address.

o Emergency Assistance for General Relief Recipients

The acute poverty of many GR recipients leaves them vulnerable to financial crises. The Department now offers an Emergency Assistance program, based on the AFDC EA program, for GR recipients. The program, which began January 1, 1985, is designed to assist those who are homeless or who are in danger of becoming homeless. It provides the same benefits as those available under AFDC EA.

D. Housing Search and Placement

In addition to addressing homeless families' immediate need for shelter, the Department provides services designed to help them find permanent housing. These services include:

- o Working with families to determine their housing needs;
- o Assistance in applying for public housing and subsidy programs;
- o Contacting landlords to locate available apartments;
- o Transportation to and from potential apartments;
- o Counseling regarding rental agreements; and
- o Provision of housing subsidies.

These services are provided cooperatively by various human services agencies. The Executive Office of Human Services coordinates the agencies' efforts and ensures the smooth running and efficiency of the cooperative programs.

o Housing Support Services

In November 1985, the Departments of Social Services and Public Welfare began a program of housing search and support services through DSS housing support staff to Welfare Department clients staying in hotels and motels. Temporary staff provided by the Department have already helped 600 families to find permanent housing.

o Outreach to Landlords

The Department is reaching out to landlords who may be reluctant to rent to homeless families. The Department has produced newspaper ads and mailings making landlords aware of the benefits offered by the Department, such as guaranteed payment of up to four months' rental arrearages, as well as the benefits of rental subsidy programs.

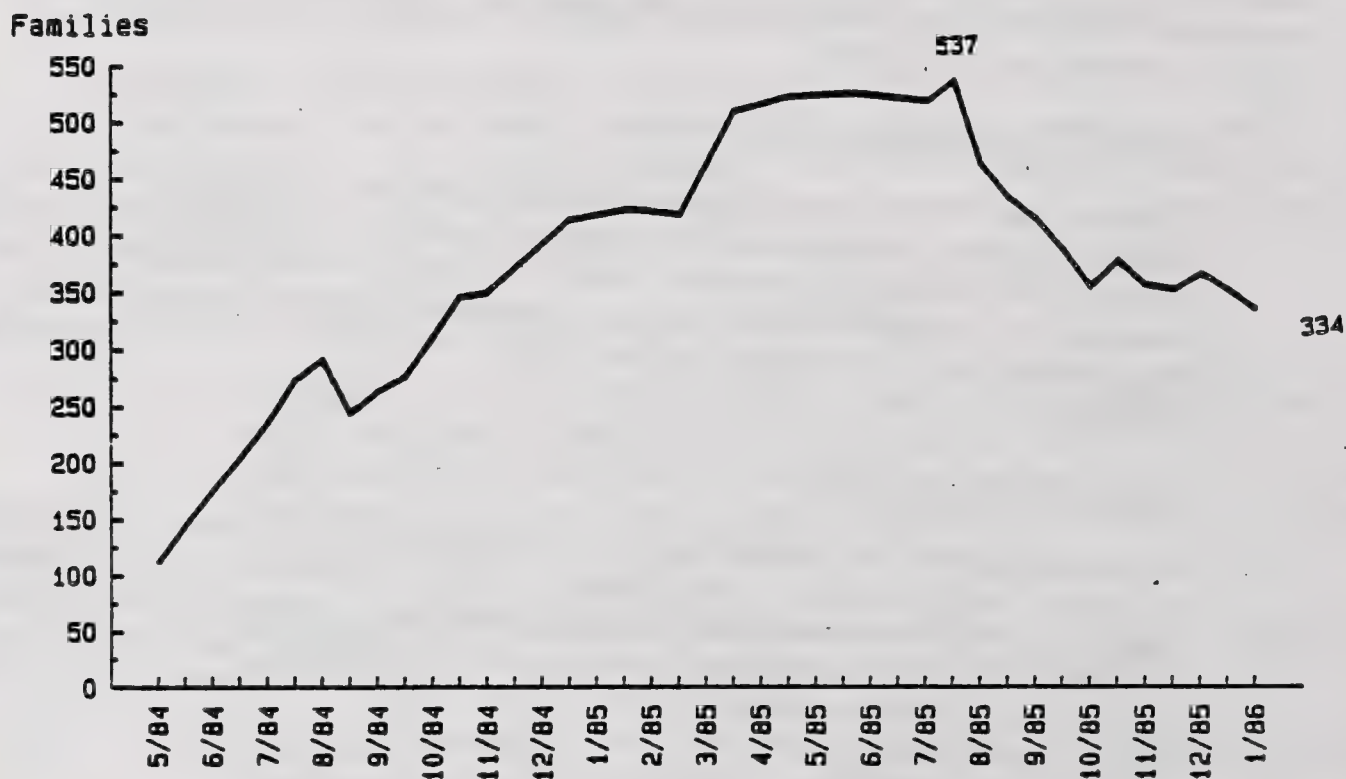
o Chapter 707 Program

The Chapter 707 Rental Assistance Program, administered by the Executive Office of Communities and Development, provides rental subsidies to enable low-income households to live in private market rental housing, a goal of particular importance considering the inadequate supply of public housing. EOCD currently administers approximately 8,500 Chapter 707 certificates, each of which provides a subsidy equal to the amount of rent in excess of 25% of the tenant's income, up to a maximum allowable fair market rent set by EOCD.

EOCD and the Department have begun a special joint program to issue 250 Chapter 707 certificates to the Department's homeless clients in hotels, motels, and shelters. Under this program, the Department will provide funding for the first year of the rental subsidy. Eligible clients are those who are homeless because of an emergency situation, including fire, natural disaster, or condemnation, abuse, a medical emergency, or conversion of housing to a condominium.

These initiatives have already been very effective in reducing the number of homeless families staying in hotels and motels. The Department's hotel/motel population, which reached a high of 537 families in July 1985, had been reduced to 334 families by January 17, 1986.

Families in Hotels and Motels May 1984 to January 1986



E. Homelessness Prevention

Many cases of homelessness are avoidable, given intervention before the family loses its home. The Department has begun or is planning three major initiatives designed to prevent homelessness.

o Housing Services through EOCD

The Housing Services Program of the Executive Office of Communities and Development, which began in FY85, has the primary goal of assisting low-income tenants experiencing housing problems to remain in their existing housing. Through contracts with non-profit agencies, EOCD provides the following services:

- Mediation of disputes between tenants and landlords;
- Workshops to introduce landlords and tenants to available assistance programs; and
- Counseling for low-income tenants on budgeting and rights and responsibilities.

In its first seven months of operation, this program directly prevented at least 225 families from becoming homeless. Over 3,500 tenants and 3,000 landlords were reached by one of the services offered.

In FY86, EOCD and the Department began a joint program to expand these services and ensure their provision to families in danger of becoming homeless. Program costs of \$220,000 include funding for twelve additional Housing Services staff.

o Stabilization Services

Many low-income families suffer from a variety of complex problems, such as a history of abuse, mental illness, or lack of household management skills. These families are in great danger of becoming homeless, and, once placed in permanent housing, of being unable to remain there.

In response to this problem, the Departments of Public Welfare and Social Services have developed a program of stabilization services to be offered to homeless families newly placed in permanent housing. These services include:

- Counseling of family members;
- Instruction in budgeting and other survival skills;
- Parenting instruction; and
- Referral to other human services agencies as needed.

F. Homeless Health Services

Besides facing substantial housing and social obstacles, the homeless frequently face difficult health problems, from psychiatric problems to chronic physical complaints. The federal Alcohol, Drug Abuse and Mental Health Administration has estimated that nearly 50% of the nation's homeless may suffer from substance abuse or serious forms of mental illness. Clearly, there exists an acute need for health care services. Another indication of this need is that three-quarters of the General Relief population, which includes many homeless and potentially homeless individuals, is eligible for cash and medical assistance because of physical or mental incapacities.

In FY85, the legislature appropriated funds for an enhanced health services package to meet the health care needs of the GR population, restoring most of the benefits available to these clients prior to FY76. These benefits include an expansion of the basic ambulatory benefit package, the opportunity to enroll in coordinated health programs, and a guarantee of access to acute hospital benefits. More detail on these benefits is provided in the description of GR Health Services elsewhere in this volume.

The homeless health services program has two major components: outreach and advocacy services, and a demonstration project, administered by the city of Boston as the recipient of Robert Wood Johnson Foundation funding, to deliver health services to homeless individuals. In FY86, the Department will spend \$416,000 for outreach and advocacy and \$250,000 for the delivery of health services.

o Outreach and Advocacy Services

For many of the homeless, obtaining needed health and social services is a task which demands and assumes a degree of stability that is not realistic, given their living situations. Although many homeless individuals may qualify for General Relief and therefore be eligible for medical benefits provided to GR recipients or for the broader medical package offered through Medicaid to recipients of Supplemental Security Income, they may need assistance in navigating the complex delivery system. With assistance, these persons could receive the benefits for which they are entitled. Specific types of social and health services depend on individual eligibility determinations. Under-utilization of health care services by the homeless population, particularly preventive health services, is of particular concern due to the high cost of episodic, acute care utilization.

In February 1985, the Department began outreach and advocacy services to homeless GR recipients and other homeless persons. The program is designed to improve this population's access to health care and to encourage participation in available state and federal programs. The Department contracts with community agencies at ten program sites across the state, who in turn evaluate individual eligibility for government programs.

encourage GR recipients to participate in preventive health care efforts, including the Department's Coordinated Health program, and assist GR and homeless recipients in obtaining necessary hospital care.

o Delivery of Health Services

In December 1984, the city of Boston was awarded a four-year \$1.4 million grant from the Robert Wood Johnson and Pew Memorial Foundations to provide free basic health care to the homeless. Boston was one of 18 cities which received an award. The award is being used to implement a health care program that serves an estimated 6,000 homeless in Boston, many of whom are in the city's major shelters. The grant covers approximately one-half of the program's costs; the state has pledged to provide \$1 million worth of matching funds. The Department provides funding for three Boston-based medical teams, consisting of a physician, nurse, and social worker from Shattuck and Boston City Hospitals who perform on-site diagnostic and outpatient services at local shelters. Where emergency services are required, physicians draw on admitting privileges granted by several hospitals.

As a short-term solution, this initiative ensures medical attention for a population that would otherwise receive few if any services until emergency services are required. This initiative, combined with advocacy and outreach, addresses the long-range goal of moving persons toward self-sufficiency by ensuring access to quality health care and to supporting programs and services.

G. Permanent Housing

In addition to providing services to meet emergency situations, the administration and the legislature have acted to address the underlying problem of insufficient housing for low and moderate income families and individuals. In 1983, the legislature enacted tough restrictions on conversion of rental housing into condominiums. In addition, EOCD and the legislature have acted to increase the supply of affordable housing. Almost 15,000 low and moderate income units have been provided to date, including:

- o 2,600 units through the Comprehensive Housing Act of 1983;
- o 3,380 units through the SHARP interest subsidy program;
- o 3,500 units by expanding rental assistance programs;
- o 4,800 units by providing moderate-income mortgages; and
- o 400 units for the mentally retarded through a consent decree agreement.

The legislature recently enacted the Housing Act of 1985, which is the largest housing bill in Massachusetts history, providing \$344.4

the largest housing bill in Massachusetts history, providing \$344.4 million for construction and rehabilitation of housing. The act includes:

- o \$101 million for 1,400 units of scattered-site family housing;
- o \$30.3 million for 800 housing units for the special-needs population;
- o \$91.5 million for renovation of existing state-assisted public housing;
- o \$35 million for renovation of deteriorated federally-assisted public housing; and
- o \$20 million for Community Development Action Grant funding which will promote home-ownership opportunities.

SERVICES TO THE HOMELESS FROM OTHER STATE AGENCIES

While the Department of Public Welfare has taken an ambitious role in addressing the problem of homelessness under the guidance of the Executive Office of Human Services, the administration has included efforts by a number of state agencies to serve the homeless.

A. Department of Social Services

DSS is the lead service agency for families in hotels and motels, providing such services as day care, camp placement for children, transportation to locate housing or employment, and parent aides, all designed to ease the stress of the families' living situations. DSS housing support specialists work with Welfare staff to help these families find permanent housing.

DSS also funds 13 information and referral services statewide and eight programs providing counseling services to families in distress related to homelessness. The agency is in the process of developing transitional living programs for high-risk families who need supervision and services to enable them to maintain independent family lives.

B. Department of Mental Health

Because many of the homeless suffer from mental illness, DMH plays an important role in providing services to this population. The agency has funded the following services:

- o a six-person case management and outreach team serving shelters in the Boston area;
- o a flexible day program offering a social club and pre-vocational program, in addition to traditional treatment;

- o the creation, with EOCD, of supportive congregate lodging houses providing residential housing and support for over 100 persons;
- o "mini-grants" enabling DMH staff to serve as liaison case managers at local homeless shelters;
- o a contract with the Massachusetts Mental Health Center to provide a six-bed homeless diagnostic and evaluation unit, a night and weekend consultation service to Boston shelters, and a series of lectures for shelter staff on psychotropic medicines; and
- o a clinician to help resettle indigent criminal addiction offenders, who are often forced into the Boston shelter system upon release.

The Governor's Comprehensive Plan to Improve Services for Chronically Mentally Ill Persons includes proposals to increase access to emergency services, to increase the availability of case management, rehabilitation, and day programs, and to increase by 2,500 the number of supported housing beds available for chronically mentally ill people. These proposals will continue to improve the Commonwealth's ability to serve the mentally ill homeless.

C. Department of Public Health

DPH runs the Lemuel Shattuck Hospital, which manages one of Boston's three large shelters. The Shattuck shelter has 100 beds. In spring 1985, DPH implemented an innovative policy of guaranteeing a homeless person a bed if he or she returned to the shelter at night. This policy helps create a social unit in the shelter and assists staff in working with the homeless by removing the daily uncertainty of finding a bed.

D. Executive Office of Communities and Development

Nearly all of EOCD's programs can be viewed as ultimately helping the homeless, since they increase the supply of affordable housing. Certain programs, though, have been specifically designed to prevent or alleviate homelessness:

- o technical assistance to a non-profit agency to help develop shelters, which was responsible for the development of more than 100 shelter beds in Greater Boston during the winter of 1984-85;
- o a program run cooperatively with Welfare to issue Chapter 707 rental subsidy certificates to families in hotels, motels, and shelters;
- o the Housing Services program, which provides counseling and mediation to families in danger of eviction;

- o new tenant selection regulations for public housing which include homelessness as a criterion for emergency placement;
- o a planning grant for a transitional housing program.

THE HOMELESS PROBLEM

Accurate figures on the number of homeless people do not exist, due to the inherent difficulties of counting this population. The 1985 Massachusetts Report on Homelessness from the Executive Office of Human Services estimated that there are 8,000 to 10,000 homeless persons statewide. 1985 figures from the Boston Emergency Shelter Commission's Plan for Boston's Homeless, however, indicate that there are 9,800 homeless men, women and children in Boston alone. There is ample evidence, despite the lack of definite figures, that homelessness is increasing. Shelters, community groups, churches and other groups report increasing demand, exceeding their capacity. Shelter directors in Boston report that they receive about 15 calls each week from homeless families that they cannot even screen because they lack room.

Further indications of increased need can be seen at Boston's Pine Street Inn, a 350-bed shelter for homeless individuals which allows people to stay on the floor or in the lobby during peak periods, rather than turning them away. During the winter of 1983, an average of 498 guests stayed at the Pine Street Inn each night. Last winter, the average was approximately 650, with a high of almost 700 on February 25. Demand this winter is even higher. The Pine Street Inn sheltered an average of 33 more guests per night in December 1985 than in December 1984. This increased request for services at the Pine Street Inn has taken place despite an increase in available Boston shelter beds from 50 to 100 at Lemuel Shattuck Hospital and from 100 to 216 at Long Island Shelter, both of which also frequently exceed their capacity during the winter.

o A New Homeless Problem: Families

Historically, the homeless population consisted largely of "street people," alcoholics and persons discharged from mental health institutions. However, the 1985 EOHS Report on Homelessness indicates that families now constitute a substantial proportion of the Massachusetts homeless population. These families, typically a mother and her children, make up a portion of the homeless population that is continuing to grow rapidly.

The exclusion of low-income families from the housing market is a serious side-effect of Massachusetts's economic prosperity and the ensuing real-estate boom. "Gentrification" of urban neighborhoods causes the displacement of low-income residents by driving up rents and property values. Condominium conversion tends to affect mainly multi-family rental units, the housing most needed by low-income families.

Homeless families are frequently recipients of AFDC. (The Plan for Boston's Homeless indicates that approximately 90% of homeless

families are female-headed households.) Families may become homeless for any of several reasons. A parent may lose a job. The family's home may be destroyed by fire or natural disaster. Serious illness may exhaust the family's savings. Income may be insufficient to pay market rents, or housing may simply not be available due to a changing market.

Homelessness puts an additional strain on families already suffering the pressure of living on a low income. It is particularly difficult for children to cope with the resulting feelings of worthlessness and fear. In a study of 52 homeless families by Dr. Ellen Bassuk of Harvard Medical School, many of the children exhibited acute psychiatric problems, and many of the preschoolers had poor language skills and underdeveloped motor and social skills. These families require help beyond the provision of overnight shelter. The Department has implemented special counseling programs in family shelters in response to this need.

o Who Are The Homeless?

The following profiles are examples of the situations that lead families to become homeless. All of the families profiled are currently residing in hotels or motels.

- Mr. and Mrs. R.T. have 3 boys, ages 4, 3, and 1, and a newborn infant. Mr. R.T. works in the laundry at Danvers State Hospital where he earns \$229 a week. The family lost its apartment in Haverhill when his sister moved out, since the family could not afford to pay the entire \$550 rent. They stayed at a shelter in Lawrence for three weeks, the maximum stay allowed. The family then lived in a tent in Harold Parker State Park in Andover for two weeks, after which they had to leave because park rules do not allow a longer stay. After several nights of sleeping in various places, including one night spent in the family car, they came to the Department and were placed in a Peabody motel. The family is having great difficulty finding an apartment they can afford where the landlord is willing to accept children.
- M.C. is a 26-year-old mother of three, two girls aged 4 and 5 1/2 and a boy of 8 months. She had always lived with her family. She was living in a trailer on her father's property, but the Mashpee Board of Health forced him to remove it, and he asked her to leave since his home was very small. The family shelter on Cape Cod is full, and landlords are wary of renting to a woman with three young children who has never previously rented on her own.
- Mr. and Mrs. F.G. are from East Boston. She is 49 years old and mentally retarded; he is 69 and confined to a wheelchair. They have two sons, one of whom is retarded. Their home burned down in February and they have been unable to find housing for the handicapped.

- R.B., 27, lives with his two-year-old daughter in a motel in Brockton. He previously lived alone in a rooming house, receiving \$99 a week in unemployment compensation. In April, his ex-wife gave him custody of their child. He could not keep the child in the rooming house and was unable to afford an apartment on his income. He is now enrolled in the Employment and Training program, which is providing day care for his daughter.
- M.D., 19, is the mother of a one-year-old daughter. She left the child's father while pregnant because he beat her severely, breaking her nose. She then moved in with her father, but he threw her out shortly after the child was born. An Early Childbearing Program in Plymouth helped her to find two roommates to share a four-room house, but one left after a month and the other wrote bad checks; M.D. was unable to pay the full rent herself, so she was evicted. She has recurring medical problems that require surgery. The child is extremely small for her age and suffers from recurring ear infections and bronchial problems.

FACTORS CONTRIBUTING TO HOMELESSNESS

A. High Rents

Of the 85,000 families on AFDC in Massachusetts, an estimated 60,000 live in unsubsidized housing. These families live in danger of homelessness as rents continue to soar. Even now, most private units are beyond the reach of AFDC recipients because they are too expensive.

- o Although nearly all AFDC recipients are potentially eligible for public housing, only an estimated 25% to 30% currently reside in public housing.
- o At \$530, the median rent in Boston is the highest in the country and above the \$432 maximum AFDC grant for a family of three.
- o Housing prices in Boston increased by more than 36% in the past year alone.
- o The Boston Emergency Shelter Commission found that 80% of homeless families rely on AFDC as their sole source of support.
- o Most AFDC recipients who live in private housing must spend a large portion of their grant on shelter and utilities. Over 63% of all AFDC families spent more than 75% of their AFDC grant on shelter and utilities, leaving the remaining 25% to cover all other necessities.

B. A Changing Housing Market

The problem of rapidly rising rents is just one symptom of the larger statewide housing problem which has resulted in the displacement of stable low-income neighborhoods. Former working-class neighborhoods

and cities have received an influx of affluent professionals who drive up property values and rents.

- o Between 1980 and mid-1983, approximately 9,000 new condominiums were added to the Boston market, almost all of which were conversions of multi-family rental units.
- o In 1950, there were approximately 25,000 licensed lodging houses in Boston, providing single-room occupancy (SRO) residences for adult individuals. In 1985, there were 250, of which 29 have been sold or converted into condominiums this year.
- o Between 1982 and 1984, 80% of Boston housing renting for less than \$300 disappeared because rents increased, units were converted into condominiums, or they became uninhabitable.

C. Lack of Sufficient Public Housing

As noted earlier, only 25 to 30% of all AFDC recipients in Massachusetts live in public housing. This is the result of a severe shortage of public housing units. Federal funding for housing assistance has decreased 60 percent since 1981.

- o Low-income families must wait years for public housing. Waiting lists of five or more years may be found in Quincy, Springfield and Holyoke.
- o In December of 1985, about 11,000 families were on the Boston Housing Authority waiting list. In August 1985, 4,200 AFDC families, or 25% of all Boston AFDC families, were on waiting lists for Boston public housing. Despite this large demand for public housing only 170 AFDC and GR families moved into public housing from January to August 1985 -- only 20 families per month. At this rate, it would take 17 years for all of the welfare families currently on the waiting list to be served.
- o A 1985 study by the Citizens' Housing and Planning Associates found that only 9% of shelter guests in Massachusetts were able to obtain public housing.

D. Deinstitutionalization

A number of the homeless are deinstitutionalized mentally ill individuals who have serious problems that often go untreated due to limited funding for community services. Without support, this population is often incapable of maintaining a job and a permanent residence.

- o The Boston Emergency Shelter Commission estimates that 32 percent of homeless individuals are mentally ill, and an additional 19 percent suffer from both mental illness and substance abuse.
- o According to Richard Ring, executive director of the Pine Street

Inn, 40 to 60 percent of that shelter's guests have mental health problems.

- o A 1985 study of Long Island Shelter of Professor Russell K. Schutt of UMass/Boston found that between one-quarter and one-half of the guests showed symptoms of psychiatric problems. Approximately 35% had previously received psychiatric treatment.
- o In a 1984 study, Dr. Ellen Bassuk, a Harvard psychiatrist, diagnosed 40 percent of the homeless men she studied as psychotic.

FY87 AGENDA

While the initiatives already undertaken have produced significant results in the prevention and alleviation of homelessness, the Department will continue to expand its efforts to respond to the needs for the homeless. In FY87, the Department is requesting funds to continue and to expand its programs.

A. Continue to Reduce Hotel/Motel Use

The Emergency Assistance (EA) program provides emergency shelter to homeless families for up to ninety days. Although temporary placement in a family shelter is preferred, for lack of alternatives these families are often housed in hotel and motel rooms. These placements are intended as a last resort in emergency situations. The rooms are crowded, many lack cooking facilities, and the family is often isolated from education, health, and social services. In addition, hotel/motel stays are very expensive, costing \$40 to \$50 per night.

In July, 1985, the number of families in hotels and motels reached a high of 537. The implementation of housing search and placement services and the Chapter 707 program helped reduce the number of families to 334 in January.

Progress has been made in three key areas:

- o Housing search staff working with the Department and DSS have successfully placed 600 hotel/motel families into permanent housing.
- o The Department is cooperating with EOCD to fund the issuance of 250 Chapter 707 rental subsidy certificates for homeless families in hotels, motels, and shelters.
- o The Department's new computerized system for paying vendors--the Special Service Payments System (SSPS) -- has been implemented. In addition to expediting vendor payments, this system will enable the Department to improve the management of EA payments, resulting in an estimated \$450,000 in savings in FY86, at no additional cost to the Department. The system

will also improve the Department's ability to identify payments that qualify for federal reimbursement.

The shelter, housing search, and homelessness prevention programs outlined earlier will enable the Department to continue reducing hotel/motel usage in FY87.

B. New Permanent Shelters

Shelters provide emergency housing for homeless families which is both superior in quality to and less expensive than that provided by hotels and motels. For a slightly lower cost per night, shelters provide many services unavailable at hotels/motels, resulting in an average stay less than half as long and an average cost per stay almost 60% lower. In addition, the services provided at shelters help stabilize families, so that they are less likely to become homeless and require emergency shelter in the future.

The Department is requesting funds to open up to five new family shelters in FY87, providing about 150 additional beds. In addition, the Department proposes to open up to five new shelters for individuals, providing about 100 new beds to serve this population, which is straining the resources of the current individual shelters.

These new shelters, if approved, will bring to 61 the total number of state-funded shelters in the Commonwealth.

FY87 BUDGET REQUEST

1. Permanent Shelters	\$ 9,834,000
2. Temporary Shelter Programs	1,005,000
3. Rehabilitation Programs	200,000
4. Additional Shelter Bed Capacity	400,000
5. Housing Search and Placement Services	646,000
6. Homelessness Prevention	<u>420,000</u>
TOTAL REQUEST	\$12,505,000

1. Permanent Shelters \$9,834,000

The Department is requesting \$9.8 million in FY87 for 30 existing permanent shelters and up to 10 new ones (five for families, five for individuals). This level of funding will support approximately 1,520 beds per night.

2. Temporary Shelter Program \$1,005,000

In FY87, the Department is requesting \$1.0 million for awards to approximately 25 community agencies. This program provides essential extra services during the winter months, when the homeless experience more severe hardship.

3. Day Rehabilitation Programs \$200,000

Most shelters for homeless individuals, unlike family shelters, are closed during the day, leaving their clients with nowhere to go. Day programs, such as the successful program at St. Francis House in Boston, address this need by providing meals, counseling, outreach, referral, and related services to homeless individuals. The Department proposes to award grants totalling \$200,000 to organizations which will start or expand day rehabilitation programs.

4. Additional Shelter Bed Capacity \$400,000

The Department proposes to continue to contract with existing shelters which are not currently state-funded to provide beds for homeless clients who would otherwise stay in hotels or motels. Shelters offer homeless families services not available in hotels and motels, such as counseling, job placement, and meals, providing a better environment.

5. Housing Search and Placement Services

\$646,000

The Department proposes to continue its agreement with the Department of Social Services for housing placements for homeless families in hotels, motels, and shelters.

6. Homelessness Prevention

\$420,000

The Department proposes to continue to fund services designed to prevent homelessness through EOCD's Housing Services program, and through a cooperative agreement with DSS for stabilization services.

REFUGEE ASSISTANCE (4409-3000)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87</u>
Expenditures	\$16,968,142	\$19,089,698*	\$22,279,991*	\$23,596,520*
Average Monthly Caseload**	2,519	2,317	2,270	2,225

The Refugee Assistance program was established by Congress with the goal of assisting newly resettled refugees to become economically self-sufficient and to make a successful adjustment to American life. The Commonwealth's refugee program is managed by the Massachusetts Office of Refugee Resettlement (MORR) located in the Welfare Department, and is 100% federally funded. Only those individuals granted refugee status by the federal government are eligible to participate. Through the program, refugees are provided with cash and medical assistance to help meet their immediate needs, and with a wide range of social services, including English as a Second Language (ESL) and employment services, designed to promote self-sufficiency by helping refugees overcome barriers to employment.

PERFORMANCE 1983-1986

Since the pilgrims arrived in Plymouth in 1620, Massachusetts has been a haven for those fleeing from political and religious persecution. The Commonwealth is continuing this historic role by:

- o Placing 1,404 refugees into employment in FY85. In FY86, the Department's goal is to place 1,000 refugees into employment through the new Refugee Employment and Education Program (REEP). In the first 5 months of FY86, refugee placements totalled 582, or 58% of the 12 month goal.
- o Increasing social services and federal grant expenditures by 90%, from \$2.0M in FY84 to \$3.8M in FY86.
- o Funding a network of community-based refugee organizations, or Mutual Assistance Associations (MAAs). These MAAs provide a number of crucial services to the refugee community, including employment and housing counseling and crisis intervention. In

*Expenditures include actual and estimated federal grant expenditures of \$0.9 million in FY85, \$1.5 million in FY86, and \$1.5 million in FY87.

**Includes cash and medical assistance cases only. Additional refugees receive social services only.

FY86, 14 MAAs will provide services to approximately 3,500 refugees.

- o Establishing a Governor's Advisory Council on Refugee Resettlement in April, 1983. The Council reviews the comprehensive annual plan for delivery of services to refugees developed by the State Coordinator of the Refugee program. In addition, the Council advises the Governor on refugee policy.
- o Adopting, by Executive Order, a state policy of nondiscrimination and protection of refugees in October 1985 -- the only policy of its kind in the nation.

FY87 AGENDA

The primary goal of the Refugee Assistance program is to promote self-sufficiency among refugees in the briefest time possible after resettlement. To meet this goal, MORR and the Department have set the following ambitious agenda for FY87:

- o 1,000 job placements through the Refugee Employment and Education Program (REEP). REEP is modeled after the Department's successful ET program and is managed by the Executive Office of Economic Affairs through the state's Job Training Partnership Act (JTPA) service delivery system. REEP provides a wide range of social services designed to promote self-sufficiency, including: English as a Second Language, employment services, vocational training, day care, and transportation.
- o Increased access to available services and resources by improving coordination among state agencies and refugee service providers. A first step in meeting this objective was a statewide planning conference held in October, 1985. As a follow-up to the conference, all participating state agencies will be submitting comprehensive service plans to the Governor's Office of Human Resources in January, 1986.
- o Expanded capacity in the refugee community to organize and deliver services through the continued support of Mutual Assistance Associations (MAAs). Community self-help models have been very successful in other states in promoting refugee self-sufficiency. In FY87, MAAs will be encouraged to seek alternative sources of funding from private donors and foundations and by applying for grants.

COMPONENTS OF THE REFUGEE ASSISTANCE PROGRAM

In order to qualify for the Refugee Assistance program, individuals must be accorded refugee status, as defined by the Refugee Act of 1980. The Act defines a refugee as any person who cannot return to his or her country of origin or last residence because of "persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion." A ceiling on the total number of refugees permitted to enter the country each year is set by the President in consultation with Congress, and

individual ceilings for each country or region are established by the State Department. Refugees are then resettled in individual states with the help of a network of sponsoring agencies known as voluntary agencies (volags). Most volags are national charitable organizations affiliated with a religious denomination.

The Department's Refugee Assistance program consists of the following components: cash and medical assistance to newly resettled refugees, the Unaccompanied Refugee Minor Program (URMP), social services through the Refugee Education and Employment Program (REEP), and a set of federal grants designed to provide unique services to meet the particular needs of specific populations or communities. Each of these components is described below:

A. Cash and Medical Assistance

Cash and medical assistance at AFDC and Medicaid benefit levels is available to all refugees meeting financial eligibility requirements for the first 18 months following the date of entry into the United States. Refugees who are categorically and financially eligible for AFDC, GR, SSI or Medicaid may receive an additional 18 months of assistance at full federal cost. An average of 2,317 cases and 5,744 recipients per month received refugee cash and medical assistance in FY85. The average monthly cash grant in FY85 was \$368.56.

B. Unaccompanied Refugee Minor Program

The Unaccompanied Refugee Minor Program (URMP) is designed to serve one of the most needy and vulnerable segments of the refugee population: teenagers and children who arrive in this country alone and who either do not have any living relatives or cannot be readily reunited with family members. Through an interagency agreement, the Department of Social Services manages this program. Services provided to refugee minors in the program include foster care, case management, and counseling. In FY87, approximately 140 refugee minors will participate in URMP at a cost of \$1.4 million.

C. Social Services

The Department receives an annual social service award from the federal government for the purpose of providing refugees with the necessary social and support services to become self-sufficient. Awards are based on a state's proportion of the national population of refugees and entrants who have been in the U.S. less than three years. Currently, with an estimated population of 9,600 refugees who have been in the country less than three years, Massachusetts ranks fifth in the nation. This population will result in a social service award of \$2.7 million in FFY86 (October, 1985 through September, 1986).

Although the amount of the award is based on the estimated number of refugees that have entered Massachusetts within the last three years,

social service programs are not limited to refugees who have been in the U.S. three years or less. Any refugee may participate, regardless of how long he or she has been in the United States. Federal guidelines require that 85% of a state's award be used for employment services and English as a Second Language, focusing on the objective of job placement.

Social services are delivered through the Refugee Employment and Education Program (REEP), which is modeled after the Department's successful ET Choices program and was implemented in FY86. The Department has an interagency agreement with the Executive Office of Economic Affairs (EOEA) to manage REEP through the Job Training Partnership Act (JTPA) service delivery system. This arrangement aids the Department in achieving its objective of increased refugee access to mainstream social services by improving coordination among state agencies and service providers.

In addition to employment services and ESL, case management and vocational training programs are funded through REEP. Case managers function like the Department's ET workers; they assess client skills and help clients to develop an appropriate employment and education plan. And, like ET participants, REEP participants are eligible to receive voucher day care and transportation allowances. In FFY86, 2,340 refugees will participate in REEP and approximately 1,350 will be placed into unsubsidized employment.

D. Federal Grants

In FY87, the Department is providing additional services above those funded in the basic social service award through several federal grant programs. The awards total \$1.5 million and provide a set of targeted services to specific populations across the state. Each is described briefly below:

o Mutual Assistance Associations

The federal government has awarded Massachusetts almost \$0.6 million since FFY84 for the purpose of developing Mutual Assistance Associations (MAAs) as service providers. MAAs are legally incorporated, non-profit, community-based organizations run by and for the refugee community. The primary goal of MAAs is to assist refugees in the often difficult adjustment to American life and transition to self-sufficiency. MAAs provide a number of crucial services to the refugee community, including crisis intervention and employment and housing counseling. Many of the MAAs have established community centers and sponsor programs and events aimed at preserving cultural identity.

After an initial period of start-up and development, MAAs will become self-sustaining organizations able to continue delivering necessary services to their communities when federal funds are no longer available. To encourage MAAs to seek alternative sources of funding from private foundations

or through other grants, MORR is issuing an RFP for a special Unmet Needs Project. In their proposals, responding vendors must document an existing and unmet need in their community (e.g. no bilingual day care), and present a plan for addressing that need. A proposal will be considered only if the vendor has obtained a firm commitment for half of the project's cost from at least one other agency or foundation.

The Department anticipates receiving an additional MAA grant from the federal government of \$150,000 in FFY86.

- o Targeted Assistance Grants (TAG)

Targeted assistance grants supplement a state's basic social service award, and are awarded to provide specialized employment services and skills training to unemployed and underemployed refugees in areas particularly impacted by high refugee populations. In Massachusetts, TAG funds programs in Middlesex and Suffolk counties.

The Department has received \$3.3 million in TAG funds from the federal government since FFY84. In FFY86, the Department has an interagency agreement with the Executive Office of Economic Affairs for the Office of Training and Employment Policy to manage a grant of \$1.3 million.

- o Enhanced Skills Training

Approximately half of refugee households in Massachusetts have at least one adult member who is unable to participate in the labor force for one or more reasons, including limited English proficiency and a lack of marketable skills. \$150,000 was awarded to the Department in FY85 to establish two training programs to respond to this problem. MORR has contracted with the Brockton Area Private Industry Council (PIC) to train refugees as machinists and home builders, and with the Southern Worcester Service Delivery Area (SDA) to train refugees with young children as certified family day care providers.

DEMOGRAPHICS

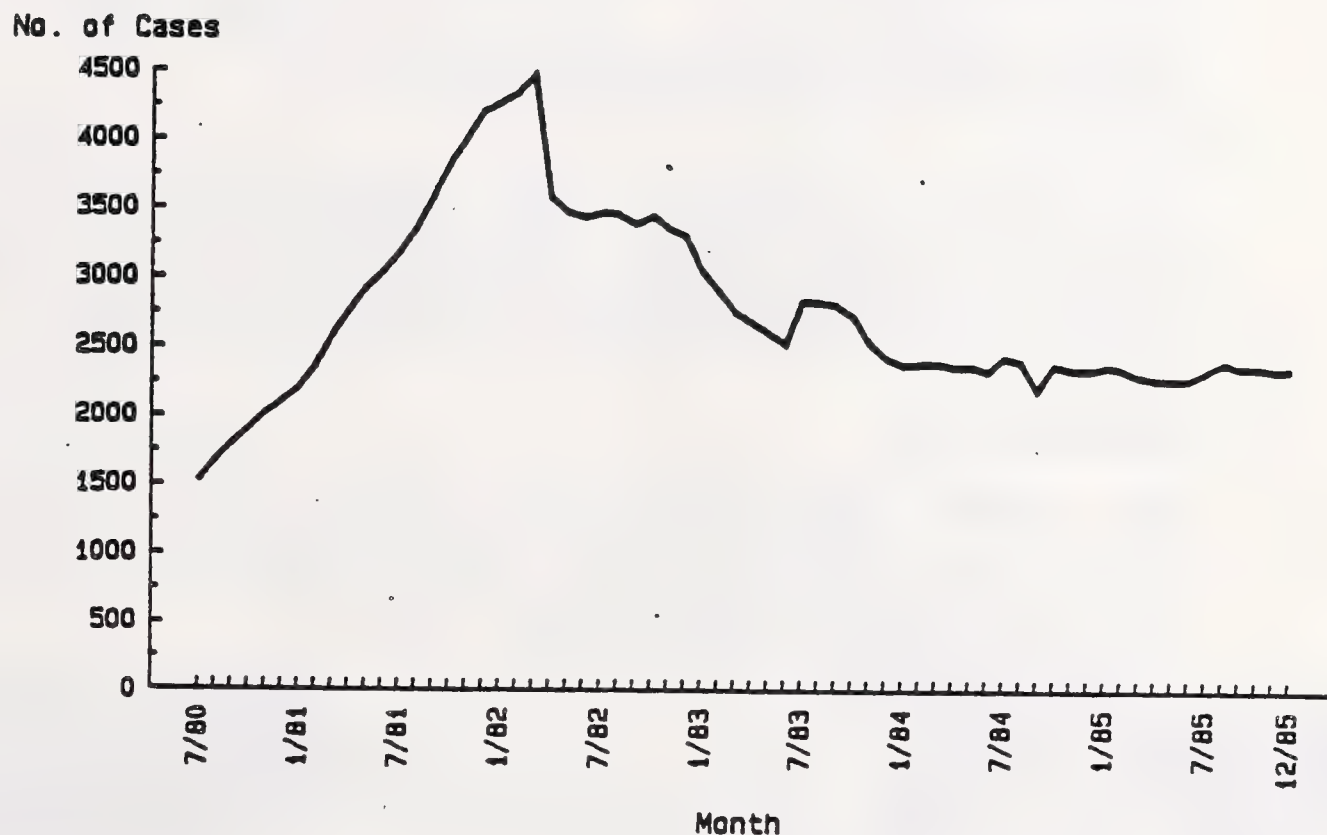
A. Caseload

The total refugee population in Massachusetts is estimated at 30,000. The December 1985 Refugee Assistance caseload was 2,353 cases or 6,193 individual recipients, however, or only 20% of the total number of refugees in the state. This difference results from the fact that the 30,000 estimate includes all refugees who have arrived since 1975, and thus many have been in the country for more

than 3 years and have become self-sufficient or are no longer eligible for refugee cash and medical assistance.

The average monthly cash and medical assistance caseload has been declining steadily since March 1982, when it peaked at 4,469 cases. This trend is due to three factors. First, in April 1982 a change in federal eligibility regulations limited assistance to an initial 18 months. Second, a large number of Indochinese refugees entered the country in 1980 and 1981, and have since left the caseload. Finally, four out of every five refugees living in Massachusetts belong to economically self-sufficient families no longer needing public assistance.

REFUGEE CASELOAD July 1980 - December 1985



B. Country of Origin

The refugee caseload is primarily Indochinese, with 91.2% of the caseload from Cambodia, Vietnam, Laos, or Thailand. The next largest group is from Eastern Europe, with 3.3% of the caseload from Russia, Czechoslovakia, or Romania. Another 2.0% is from Ethiopia. The remaining 3.5% of the caseload includes recipients from Afghanistan, Chile, Indonesia, China, Cuba, Haiti, and other countries.

C. Type of Assistance

45.0% of the Refugee Assistance caseload is categorically eligible for AFDC and receives cash and medical assistance at AFDC and Medicaid benefit levels for a maximum of 36 months from date of entry into the country (AFDC-eligible cases). Another 48.6% of the caseload does not meet the categorical eligibility requirements for AFDC, but has been in the country for 18 months or less and thus also receives cash and medical assistance at AFDC and Medicaid benefit levels (Non-AFDC cases). The remaining 6.4% of the caseload receives medical assistance only. Currently, the average length of stay on refugee cash and medical assistance is 16 months for non-AFDC refugee cases, and 27 months for AFDC-eligible cases.

In the first two quarters of FY86, an average of 150 General Relief (GR) cases per month were refugee households who have been in the country less than 36 months. Although these cases are considered to be part of the GR caseload, 100% of the costs of providing assistance to these families is reimbursed by the federal government.

D. Household Size

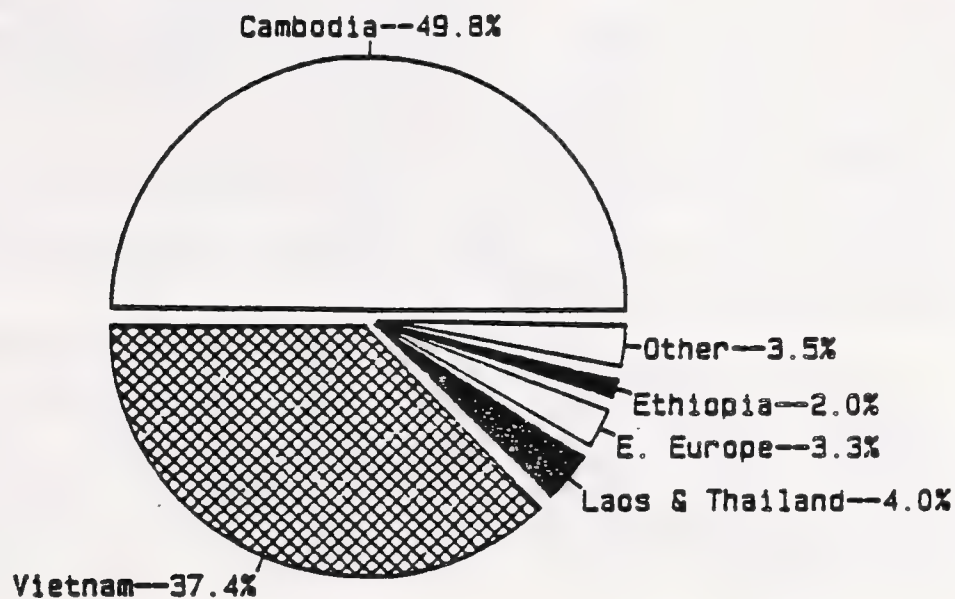
Most refugee cases are small; 45.5% of all cases contain a single individual. Another 34.5% contain between 2 and 4 individuals. The small average case size of 2.5 reflects the fact that all dependents over the age of 18 are counted as separate households, and that many refugees are single individuals.

E. Age and Sex

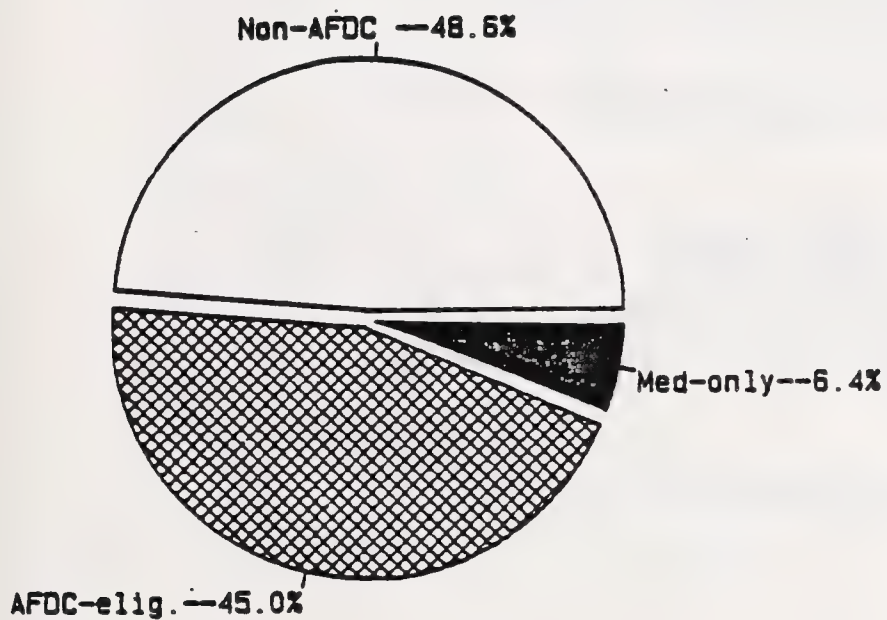
41% of Refugee Assistance recipients are dependents under the age of 18. An additional 37% are individuals under the age of 35. The remaining 22% are over the age of 36.

63.4% of refugee households are headed by men, in contrast to the AFDC caseload, where over 90% of AFDC parents are women. A large number of refugee households are made up of young, single men who fled their countries without their families.

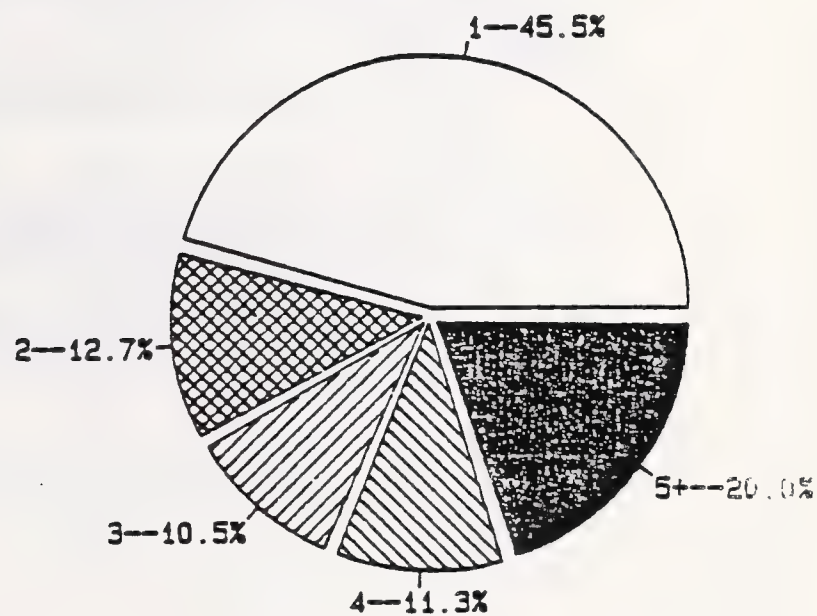
REFUGEE CASELOAD DEMOGRAPHICS FY86



Country of Origin



Type of Assistance



Household Size

F. Geographic Distribution

The distribution of refugees throughout the fifty states is determined by a number of factors, including distance from a point of entry into the country, location of family members already resettled in the country, and the capacity of voluntary agencies to sponsor refugees. Most refugees are located in just a few states. More than half of the refugees who arrived in the U.S. between October 1982 and November 1984 were resettled in only six states, of which Massachusetts was one. New arrivals to Massachusetts are expected to be 216 per month in FY87.

In Massachusetts, almost three-quarters (73.9%) of the refugee caseload lives in only 7 communities: Boston, Brookline, Chelsea, Lowell, Lynn, Newton, and Worcester. Well over half (55.7%) of refugee cases live in Boston, Chelsea, and Lowell. In fact, the Chelsea and Lowell local offices have the highest refugee caseloads in the state.

FY87 SPENDING

The Department estimates total expenditures of \$23,596,520 for the Refugee Resettlement Program in FY87. These expenditures will support cash and medical assistance to an average of 2,225 refugee cases per month, social services for a population of 4,332 refugees through the Refugee Employment and Education Program (REEP), the Unaccompanied Refugee Minor Program (URMP), federal grant programs, and administrative expenses.

1. Cash Assistance	\$11,032,949
2. Medical Assistance	5,218,625
3. Unaccompanied Refugee Minor Program	1,400,000
4. Social Services	2,927,446
5. Federal Grant Programs	1,540,000
6. Administrative Expenses*	<u>1,477,500</u>
TOTAL	\$23,596,520

*Administrative expenses include the costs of MORR personnel, travel and conferences, equipment and supplies, and indirect administrative costs charged to MORR by the Department.

INTRODUCTION TO HEALTH SERVICES

In FY87, the Department proposes to provide health services totalling \$1.308 billion through four accounts:

- o Medical Assistance (4402-5000)
- o Medical Assistance-Mental Health (4402-5300)
- o General Relief Health Services (4406-5000)
- o Employment and Training Health Choices (4407-1012)

Three smaller accounts, totalling \$33.4 million in proposed spending authority, fund most of the administrative expenses associated with managing the programs and processing provider bills. These accounts are:

- o Project Good Health (4400-1400)
- o Medicaid Management (4400-1003)
- o MMIS (4400-1012)

This section of the narrative starts with a discussion of the Medical Assistance program, including a review of recent program and savings initiatives and a description of the FY87 agenda. Following the Medicaid narrative is a special report on Health Choices for Families and Children, the first stage of the Department's proposal to restructure the Medicaid program so that it offers low-income people the same health care options available to other citizens of the Commonwealth.

The Medicaid-Mental Health, General Relief Health Services and Project Good Health narratives appear next. Employment and Training Health Choices is included in the Employment and Training section earlier in this volume; Medicaid Management and Medicaid Systems are included in the Direct Service and Management section later in this volume.

MEDICAL ASSISTANCE (4402-5000)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures /Appropriation	\$1,077,328,509	1,162,920,000	1,232,197,000	1,237,140,000
Caseload	259,900	259,100	260,500	261,400
Recipients	442,600	434,500	434,000	435,800

OVERVIEW

Medical Assistance (Medicaid) is a joint state and federally funded, state-administered program responsible for making necessary and high quality medical care available to financially and medically needy individuals efficiently and cost-effectively. Medicaid does not provide the care directly. Instead, it reimburses medical care providers, such as physicians, clinics, hospitals and nursing homes, for services they render to Medicaid-eligible individuals. The Medicaid program is the largest single item in the state's budget.

The 1965 enactment of Title XIX of the Social Security Act established the Medicaid program. The Health Care Financing Administration (HCFA) of the federal Department of Health and Human Services is responsible for monitoring state compliance with federal Medicaid regulations. States must comply with these regulations to receive federal reimbursement for their Medicaid expenditures. In FY86, Massachusetts is currently being reimbursed for 50% of Medicaid expenditures.

A. Caseload Composition

Individuals become eligible for Medicaid primarily on the basis of their income and financial resources. The principal elements of the caseload are:

- o Categorically Needy. All persons who receive cash assistance, from the Aid to Families with Dependent Children (AFDC) program, the Supplemental Security Income (SSI) program, or the Refugee Resettlement program, are automatically, or categorically, eligible for Medicaid. For the first half of FY86, the average monthly caseload of categorically needy was about 195,000; the average monthly recipient count was about 351,000.
- o Medically Needy. Individuals and families who are financially ineligible for cash assistance but whose income and resources are insufficient to meet their medical needs and who are within prescribed eligibility limits are eligible for Medicaid-only. In addition, families or individuals (except childless, able-bodied persons between the ages of 21 and 65) can qualify for Medicaid as medically needy if they have high

medical expenses which reduce their income below the medically needy monthly income standard (\$509 for a family of four in FY86). These people are medically needy spend-down cases.

Those who qualify for Medicaid on this basis are mostly elderly and disabled persons, many of whom are in nursing homes and chronic disease and rehabilitation hospitals. In the first half of FY86, the average monthly Medicaid-only caseload was about 65,500, and the average monthly Medicaid-only recipient count was about 83,000. Most Medicaid-only cases include only one individual.

FY86 Medicaid Caseload Composition

<u>Eligibility</u>	<u>Average Monthly Caseload</u>	<u>% of Caseload</u>	<u>Average Monthly Recipient Count</u>	<u>% of Recipient Count</u>
Categorical	195,000	75%	351,000	81%
Medicaid-Only	65,500	25%	83,000	19%
Total	260,500	100%	434,000	100%

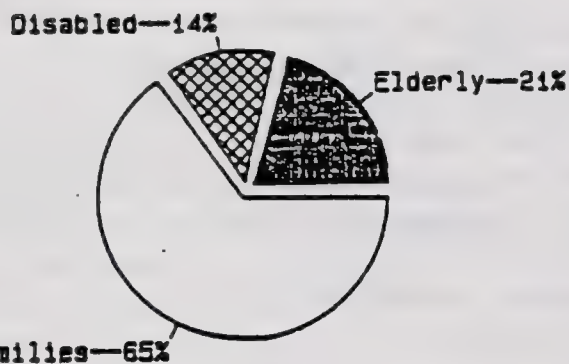
B. Covered Services

Federal Medicaid regulations require states to provide a specified set of medical services to Medicaid recipients. States have the option of providing certain additional services. The services Massachusetts provides include all the mandatory services (inpatient and outpatient hospital care, skilled nursing home care, physician services, laboratory and radiology care, home health care, and dental and preventive health care for children). In addition, Massachusetts provides a comprehensive package of optional benefits (30 services), including prescribed drugs, intermediate care nursing homes, adult day health care, mental health care, and transportation to medical services.

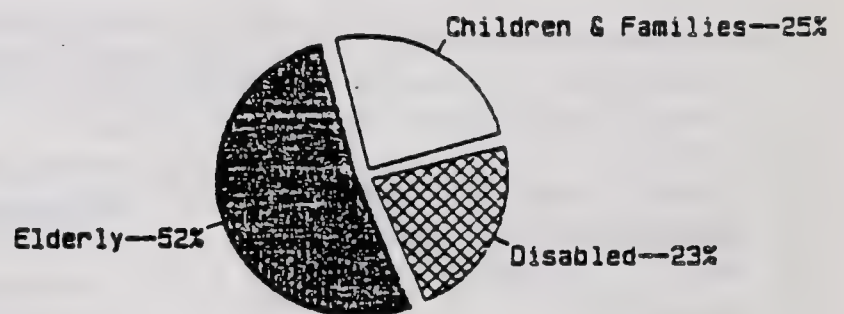
C. Expenditure Distribution

Most Medicaid recipients (65%) are children in impoverished families and their single and/or unemployed parents. Because these families frequently utilize only routine ambulatory care and acute hospital inpatient services, as opposed to nursing home care, they account for only 25% of the state's Medicaid expenditures. Elderly and disabled recipients comprise 35% of Medicaid recipients but account for 75% of expenditures.

DISTRIBUTION OF MEDICAID RECIPIENTS



Percent of
Total Recipients



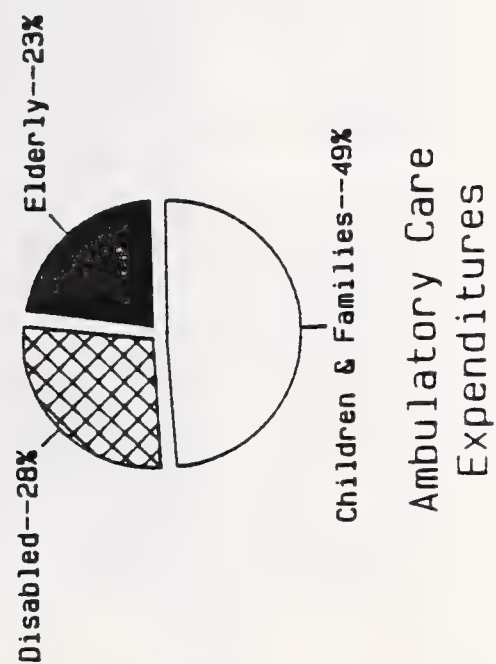
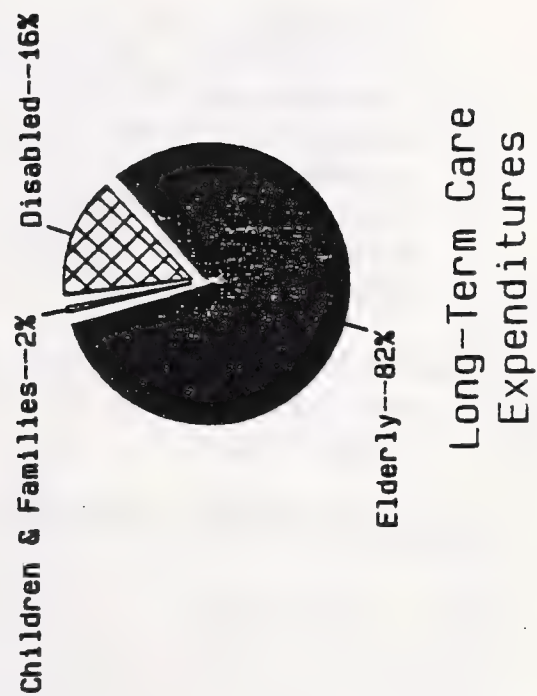
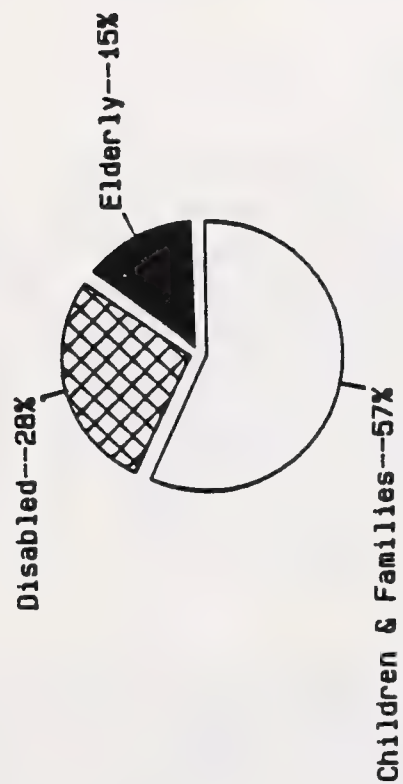
Percent of
Total Expenditures

Each year, about 70% of the Medicaid budget is spent on institutional care. Of this amount, about 50% of the total budget is spent for long-term care services provided in nursing homes and chronic disease and rehabilitation hospitals; and about 20% is spent for acute hospital inpatient services. The balance of the overall budget, about 20%, is spent on noninstitutional services, including acute hospital outpatient services, physician care, pharmacy, and home health.

PROJECTED FY87 EXPENDITURES BY PROVIDER TYPE

<u>PROVIDER TYPE</u>	<u>FY87 EXPENDITURE (\$M)</u>	<u>% OF TOTAL EXPENDITURES</u>
Intermediate Care Facility	\$ 283.6	22.9%
Inpatient Hospital	243.5	19.7%
Skilled Nursing Facility	206.8	16.7%
Chronic Hospital	154.9	12.5%
Outpatient Hospital	118.1	9.5%
Pharmacy	71.0	5.7%
Physician	60.0	4.9%
Home Health	31.0	2.5%
Dentist	21.7	1.8%
Other	46.5	3.8%
Total	\$1,237.1	100.0%

DISTRIBUTION OF EXPENDITURES BY CATEGORY



1983-1986 PERFORMANCE

In the FY85 and FY86 budget narratives, the Department identified six major objectives in order for the Medicaid program to meet its goal of ensuring access to quality, cost-effective health care services for the poor, the disabled, and the elderly. These objectives included:

- o containing the cost of the Medicaid program;
- o implementing and effectively operating the Medicaid Management Information System;
- o expansion of the coordinated health program;
- o improving access to health care;
- o improving the quality and cost-effectiveness of services for the elderly and disabled; and
- o managing Medicaid eligibility.

A summary of Medicaid savings and program developments over the last three years shows that the Department has made substantial progress in most of these areas.

A. Medicaid Savings and MMIS Implementation

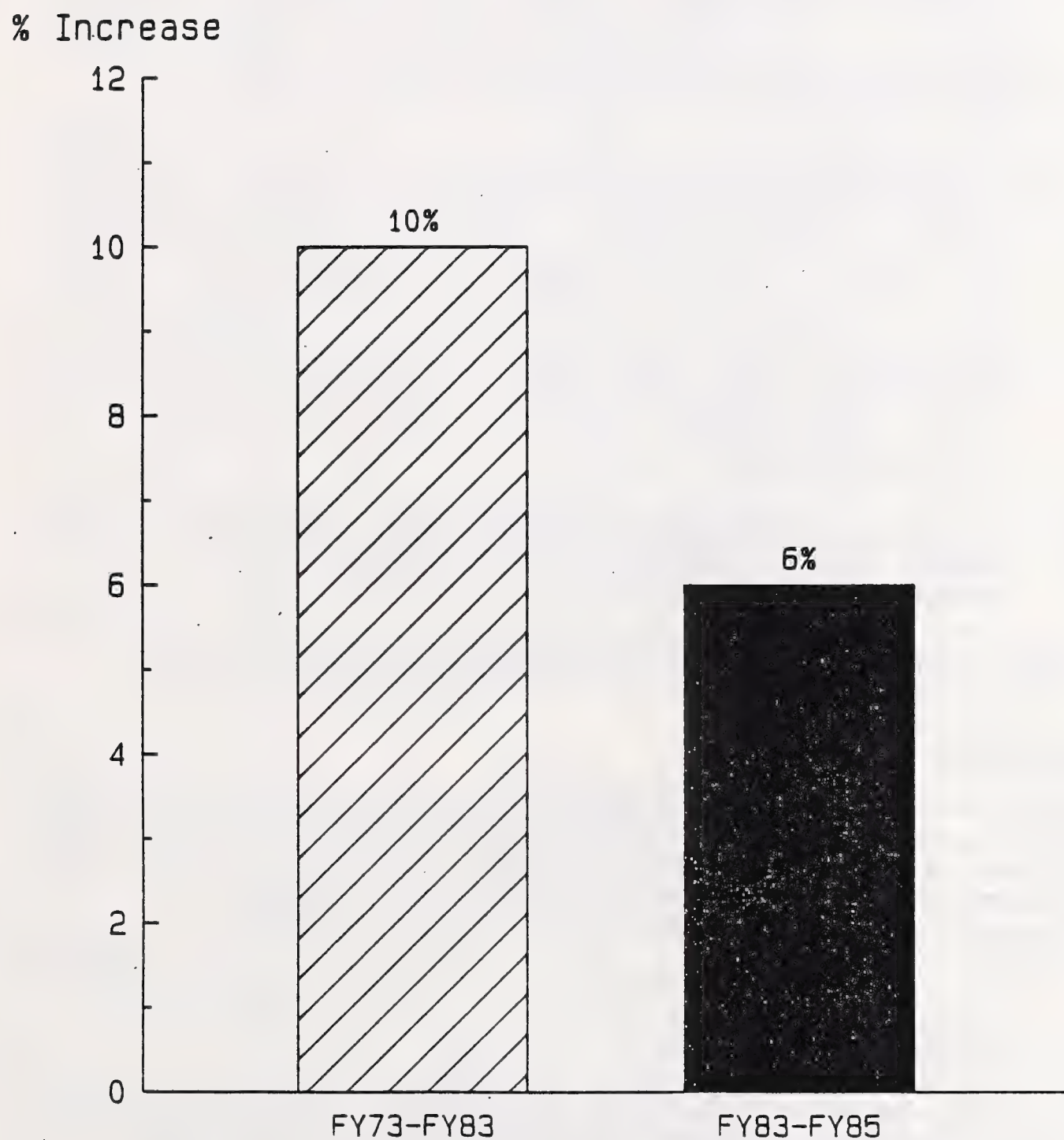
The Department's Medicaid savings initiatives have played an important role in controlling state health care costs -- and have achieved this control by correcting inefficiencies rather than reducing services. Medicaid savings in FY85 totalled \$49 million*; in FY84, Medicaid savings totalled a record \$74 million*. Moreover, the Department had already realized continuing Medicaid savings totalling \$32 million from FY82 and FY83 activities. In other words, \$155 million in unnecessary costs were eliminated from the Medicaid program through FY85. These funds were available to finance key priorities in recent state budgets, including a 9% increase in AFDC grants in FY86, and to finance legislative repeal of the surtax on income taxes.

Perhaps the best indicator of the Department's success in controlling costs is a comparison of the recent average annual Medicaid spending growth rate and the growth rate in previous years. As the chart on the following page indicates, Medicaid spending increased by an average of just 6% annually over the period FY84 and FY85. By comparison the average annual rate of spending growth over the period FY74-FY83 was 10%.

Establishment of rigorous cost controls in combination with innovative program initiatives enabled the Department to realize these savings. Key savings initiatives included:

* Net of \$10 million in FY85 and \$15 million in FY84 for unintended Chapter 372 hospital savings.

AVERAGE ANNUAL PERCENTAGE INCREASE IN MEDICAL ASSISTANCE SPENDING



- o In FY84, the Department implemented the Medicaid Management Information System, which replaced three separate claims processing systems with a unified and vastly more sophisticated claims processing management information system. Of the \$74 million saved in FY84, MMIS was responsible for more than \$36 million through eliminating payment of duplicate claims and through other edits. In FY85, as the system completed its first full year of the edit and other capabilities that yielded these savings, it produced further savings of \$20 million. Recently, the Department has begun full use of the Surveillance and Utilization Review Subsystem (SURS) and other more advanced aspects of MMIS. These capabilities are a key element in the FY87 savings agenda.
- o The Third-Party Liability Unit achieved a substantial increase in identification of recipients with other health insurance coverage. Annual savings of approximately \$600 per recipient identification result from the denial of payment for claims where other insurance coverage (third-party liability or TPL) exists. More than 31,000 new TPL identifications were made in FY84 and FY85 with an attendant cumulative savings value of \$20 million. The total number of recipients identified as having other health insurance coverage at the end of FY85 equalled about 49,000, representing almost a tripling of the FY83 year-end total of 17,000.
- o The Provider Review and Sanctions Unit, through financial and program audits, recouped \$6.3 million in FY85, \$3.7 million more than collected in FY83 -- an increase of 142%.

Further, in the first half of FY86, the Department achieved over \$5 million in new Medicaid savings from these and other initiatives.

B. Coordinated Health

Because coordinated health addresses the fiscal and continuity-of-care problems inherent in Medicaid's present fee-for-service health delivery system, increased recipient enrollment and provider participation in coordinated health is a critical goal. The Department's efforts in this area produced the following:

- o Enrollment in the Department's coordinated health programs increased from 7,830 at the end of FY83 to almost 12,700 at the end of FY85.
- o The Department developed four new program models, three of which are specifically designed to serve elderly individuals. This establishes the foundation for significant savings in the future.
- o In FY85, the Department made coordinated health services available to General Relief recipients. This benefit is an important component of the expanded General Relief health services program, implemented in November 1984.

C. Access and Quality of Care

In cooperation with the legislature and with other human service agencies, the Department has implemented the following initiatives designed to improve access to quality health care for low-income individuals:

- o Reopening the Medicaid unit at Boston City Hospital to respond to the unique health care needs of a population in a geographic area with a high concentration of Medicaid recipients and the working poor.
- o Expanding the medical services package for General Relief recipients. The new plan includes comprehensive ambulatory care benefits, coordinated health benefits, and access to hospital services through an agreement, enacted in legislation, among the state, the hospitals, and private third-party payers. A detailed description of this program is included in the General Relief Health Services account narrative (4406-5000).
- o Establishing a global fee for obstetric delivery and prenatal and postnatal visits. This approach should result in improved availability of obstetric and gynecological care.
- o Increasing physician rates -- from \$11.50 to \$21 for a routine office visit -- and streamlining the provider enrollment process to promote primary care through greater participation of physicians in the Medicaid program. Moreover, the state and the Massachusetts Medical Society entered an agreement which outlines voluntary measures designed to increase physician participation in the Medicaid program. The goal is to enroll 85% of the state's actively practicing physicians by the end of FY86.
- o Implementing a federally approved home- and community-based waiver project to provide Medicaid reimbursement for personal emergency response system services to a select group of elderly and disabled individuals at risk of institutionalization. In FY86, these services will help enable up to 600 elderly and disabled recipients to remain in their own homes instead of moving into nursing homes or chronic disease hospitals.
- o Completing statewide coverage by the Department's nursing home prescreening program in FY84, and important program reforms in FY86. Prescreening ensures appropriate institutional or community placement of all Medicaid recipients seeking nursing home care. Private patients who anticipate eventually applying for Medicaid are also encouraged to participate.
- o In conjunction with the Department of Public Health (DPH), establishing a program to provide prenatal and postnatal care

for uninsured low-income pregnant women who otherwise would have no guaranteed financial support for adequate care. (In FY87 these services are proposed to be funded through the DPH budget.)

- o Increasing the Medicaid-only income-eligibility standards to enable more working poor families to secure medical coverage.

D. Managing Medicaid Eligibility

In FY84 and FY85, the Department improved management of the Medicaid eligibility process through the following initiatives:

- o Establishment of a new regional long-term care eligibility unit in Worcester. The addition of this unit to those that already operate in Springfield, Lawrence, Taunton, and Boston means that these units, staffed by specially trained workers, will handle virtually all long-term care eligibility determinations. Because of the complexity of long-term care cases, concentrating them in specialized units has both reduced the error rate and improved the timeliness of eligibility decisions.
- o Reduction in the Medicaid error rate from 6.6% to 1.2%, the lowest in the Department's history, due to continued efforts to improve Medicaid eligibility determinations.
- o Development and successful implementation in FY85 of an action plan to reduce the redetermination backlog due to the MAOA decision.

FY87 MEDICAID AGENDA

In order for the Medicaid program to make further progress toward its goal of ensuring access to quality, cost-effective health care services for the poor, the disabled, and the elderly, the Department plans in FY87 to redouble its efforts in four major areas: (a) containing the cost of the Medicaid program; (b) restructuring the Medicaid program in order to improve quality; (c) improving access to health care; and (d) caring for the elderly.

A. Containing the Cost of the Medicaid Program

Despite recent cost-control efforts, Medicaid spending in Massachusetts has grown substantially. At a projected \$1.23 billion for FY86, it will have more than doubled since FY77 and is the largest item in the state budget, representing about 15% of the total budget. Compared to other states, in federal fiscal year 1984 Massachusetts ranked seventh in total Medicaid payments. Massachusetts Medicaid spending is comparable to other major industrial states (eg., Pennsylvania, Illinois, Michigan, and Ohio) and is more than the total combined payments of all the other states in the New England region.

Moreover, health care inflation, which traditionally exceeds general consumer price increases by at least two percentage points and is projected at 6.3% in FY87, is a substantial problem for the Commonwealth because of the effect that it has on Medicaid expenditures. The impact of a 6.3% inflation rate on the Medicaid budget is in excess of \$74 million. To a large extent, this represents a fixed-cost item that will recur annually. Annual cost increases of this magnitude absorb a significant amount of discretionary monies, thus severely constricting the availability of funds for other critical human service priorities.

The magnitude of the Medicaid budget, combined with significant annual fixed-cost increases due to inflation, requires the Department to implement savings initiatives in order to moderate spending growth. Stated simply, if left unmanaged, the Medicaid budget alone would absorb all new money available to the Department and, indeed, a substantial portion of the Commonwealth's growth revenue.

In response to these basic fiscal realities, the Department has developed and implemented an annual Medicaid savings agenda for a number of years. Indeed, without successful achievement of the annual Medicaid cost savings agenda, the Department and the Commonwealth would not be able to finance other key program priorities or ensure continuation of the comprehensive Medicaid service package. Specifically, as noted above, in the absence of the savings agenda through FY85, the Medicaid program would have required an additional \$155 million in the FY85 budget to cover program costs. Moreover, if the Department meets its proposed FY86 savings target, it will have reduced the expenditure base by \$220 million.

The Department has achieved these savings by: (a) installing a new computer which denies inappropriate claims and provides critical management information; (b) proposing and/or supporting cost-effective changes in the rate setting for health care services; (c) ensuring that services provided are necessary and are provided in the most cost-effective setting; (d) developing innovative methods of delivering quality services at lower cost; (e) ensuring that Medicaid recipients make maximum use of any private insurance coverage that they have available; and (f) auditing providers to curb fraud.

In FY87, the Department proposes additional savings of \$42.25 million in the Medical Assistance account. The Department plans to achieve these savings through a continued emphasis on management initiatives which yield savings without endangering quality of or access to care. These initiatives include a significantly fuller application of the Department's new Medicaid Management Information System. (Table A, located at the conclusion of this section, provides a brief description of each savings initiative). The FY87 agenda includes several major components:

Third-Party Liability. Through a combination of several initiatives, particularly increased identification of recipients with private health insurance coverage, the Department anticipates appropriately redirecting claims worth about \$13 million to the other legally responsible insurers in FY87. By the end of FY87 almost 56,000 recipients with health insurance coverage will have been identified, representing a tripling of identifications over the FY83 endpoint of 17,000.

Utilization Review. Consistent with utilization review practices implemented by other private and public payers, the Department is considering implementation of an acute hospital preadmission screening program for elective admissions. For the first time, the Department would determine prior to admission the medical necessity of the procedure, and appropriateness and cost effectiveness of the health care delivery site. The program is intended to ensure quality of care by reducing the number of inappropriate and unnecessary acute hospital admissions.

MMIS. The Department will capitalize further on the informational features of MMIS in an effort to influence provider practice patterns in the direction of utilization norms. Specifically, patterned on the small-area comparison analysis (pioneered by researchers at Dartmouth College and Harvard University), the Department will use the Surveillance Utilization Review Subsystem (SURS) and reports from other data bases to compare health care providers and the services they offer with other providers and with practice norms. Currently, many providers are furnishing an unusually large amount of services compared with Medicaid or general health care averages. These variances may be justified, but they may also indicate excessive and inappropriate utilization of services. The advanced capabilities of SURS, in combination with other reports, will allow the Department, for the first time, to direct attention to unusual patterns of activity that would otherwise be undetectable.

The Department will issue to the relevant professional organizations and key individual providers and institutions a series of analyses both to serve as an educational tool and to indicate appropriate changes in provider practice patterns. The Department intends to meet primarily with providers whose treatment regimen for comparable diagnoses is statistically atypical relative to their peers. Such providers are considered to be outliers because behavior is outside the norm. The Department will discuss the specific findings with these providers, highlighting the treatment pattern variations among their peer groups by diagnosis. The Department will seek explanations and, where appropriate, corrective action plans and will monitor these providers' subsequent practice patterns to determine whether appropriate utilization changes have occurred.

There might be some concern over the fact that the Department is projecting significant savings from this initiative, about \$10 million, without any certainty that providers will alter their behavior. However, results of previous studies suggest that, despite

initial resistance, the majority of the provider community tends to respond in a pragmatic fashion to objective data. In fact, utilization reductions of up to 11% have been documented for certain hospital services. The Department is projecting (based on available information about discrepancies between provider practices and utilization norms) an average 4% reduction in utilization for acute hospital and primary care services in FY87 due to changes which should occur in provider practice patterns. In the event that the providers involved do not satisfactorily explain or voluntarily amend unusual practice patterns, the Department will perform audits and, if necessary, promulgate specific regulatory initiatives, based on the information contained in the utilization reports, to ensure that necessary changes occur. (A further description of this initiative is included in the utilization section of this narrative.)

B. Improving Quality of Care: HEALTH CHOICES FOR FAMILIES AND CHILDREN

For FY87, the Department is proposing a restructuring of the existing Medicaid program for families and children, from a predominantly fee-for-service based system which does not ensure appropriate utilization of or access to health care services, to a three-pronged system which would be designed to better ensure comprehensive, high-quality care delivered in a more cost-effective fashion.

In developing this proposal, the Department has placed a premium on meeting the needs of the clients through the proposed establishment of a Medicaid delivery system which would mirror the care choices available to non-poor citizens of the Commonwealth. Under two of the Health Choices, clients would trade their Medicaid cards for health plan or insurer cards. This would make Medicaid clients indistinguishable from other plan members. Specifically, the three health care options are:

- o Private Insurance Program - under a negotiated agreement between the state and one or more prospective private insurers, a new health care option for Medicaid-eligible families would be a private insurance plan such as Blue Cross Master Health Plus or Prudential Care.
- o Coordinated Health Program - a single primary care provider (i.e., community health center, health maintenance organization, or physician), under a prepaid financing agreement, provides or authorizes all necessary health care services.
- o Basic Medicaid - a revamped fee-for-service reimbursement system which incorporates generally accepted utilization control measures.

The Department proposes that a portion of the savings which results from the clients' decision to participate in the HEALTH CHOICES program be shared with the clients directly, or retained and invested in programs that help low-income individuals become independent of

public assistance and move out of poverty. (A special report on the HEALTH CHOICES program follows the Medicaid narrative.)

C. Improving Access to Health Care

In FY87, the Department plans to continue its efforts to improve access to health care for low-income individuals. Implementation of the HEALTH CHOICES program is one way to achieve this objective. The other key FY87 access proposals include:

- o providing Medicaid coverage to more people through a 10% increase in the AFDC payment standard. This initiative would ensure medical coverage to 900 additional families, who otherwise would probably have no coverage.
- o enlisting more primary care providers (particularly family physicians, gynecologists, obstetricians, and dentists) in the Medicaid program in order to ensure availability of critical services throughout the state. This effort will include a continuation of negotiations with specific providers in order to resolve a spectrum of financial, administrative, and other problems which the providers see as justifying a decision not to participate in Medicaid.
- o providing more preventive medical care to children through expanded enrollment in Project Good Health.
- o establishing an Employment and Training (ET) Health Choices program, which would guarantee one year of continued health coverage for up to 2,250 ET participants who find jobs which do not include insurance. The proposed ET Health Choices program would complement the Department's current voucher day care initiative, which makes day care services available to ET participants for the critical first 12 months of employment.

D. Caring for the Elderly

One of the most serious problems confronting the Commonwealth in general and Medicaid program in particular is how to provide affordable, quality care to a growing elderly population. In FY85, the Department spent over \$625 million, or about 54% of the Medicaid budget for health services for the elderly. Of this amount, approximately \$550 million were allocated for institutional care. In stark contrast, less than \$100 million, or only 14%, were spent on ambulatory and alternative noninstitutional care.

The Department's continuing goal in FY87 is to ensure that elderly individuals are treated at all times with dignity and have the maximum opportunity to live in the least restrictive possible setting consistent with their social and medical needs.

Specific proposals, described in more detail below in the discussion of caring for the elderly, include:

- o developing a more comprehensive and flexible system which responds to the diverse needs of the elderly population through early intervention and efficient case management of resources. One management model for this system is the Employment and Training program, which uses performance-based contracting and client choice among services, to enable self-sufficiency and to move clients off welfare and out of poverty. The Department believes that it may be possible for it and other state agencies to develop a similar system of elderly service delivery, toward the goal of maximizing availability of realistic choices other than nursing homes;
- o better management of, and where necessary, expansion of noninstitutional services designed to help the elderly remain in the community;
- o exploring new residential alternatives, including life care communities, to prevent premature and/or unnecessary institutional placement;
- o improved management of nursing home resources; and
- o distributing more evenly among payers the costs of institutional and noninstitutional long-term care. Expanded availability of private long-term care insurance is a key element of this effort.

FY87 MEDICAID SAVINGS AGENDA

PROJECTED
FY87 SAVINGS
(\$M)

DESCRIPTION

INITIATIVE

Third Party Liability	13.65	This represents an expansion of FY86 initiatives and the ongoing implementation of new efforts aimed at maximizing the amount of private insurance payments made on behalf of Medicaid recipients. Initiatives include increased private health insurance identifications, maximizing Medicare coverage and increasing the number of recipients receiving veterans' benefits.
Provider Practice Patterns	10.00	Medicaid savings may be achieved by focusing on provider service and billing patterns in order to modify patterns of providing unnecessary services to clients. Through analysis and comparison of provider behavior, the Department will document ranges of statistically acceptable utilization behavior. By accessing a range of health care databases, the Department will be able to identify those providers whose practice patterns differ from these norms. Based on this work, the Department will: o use provider-specific mailings and meetings to explain to providers how their practice patterns differ from anticipated patterns. Providers will have an opportunity to explain why they are furnishing larger amounts of services than their peers.

INITIATIVE

DESCRIPTION

Provider Practice Patterns (cont.)

- o establish corrective action plans with providers and provider associations where there is clear evidence of unusual patterns in service delivery.
- o monitor provider compliance with corrective action plans.
- o use clinical audits and increases in the number of procedures needing prior approval in order to correct continuing patterns of excessive service delivery.
- o reward providers offering high-quality care which responds to client conditions rather than being either substantially more or substantially less than clients need.

Hospitals, laboratories, radiologists, and pharmacies -- which together will account for more than \$425 million in spending in FY87-- will be among the provider types receiving the closest attention.

Provider Review and Sanctions

8.0

The Provider Review and Sanctions Unit (PRSU) is responsible for monitoring the Medicaid program for provider fraud, abuse and regulatory non-compliance. This monitoring differs from that described above in that PRSU focuses on financial issues and whether services billed for were actually delivered, while the Provider Practice Patterns project

PROJECTED
FY87 SAVINGS
(\$M)

INITIATIVE

DESCRIPTION

Provider Review and Sanctions (cont.)

focuses on whether services provided were excessive. In FY87, the Department anticipates recoveries of \$8 million through increasing the number of audits conducted and updating audit work programs, particularly in the following areas: pharmacy; laboratory; radiology; nursing homes; and chronic hospitals.

MMIS Edits

4.6

During its first twelve months of operations, MMIS saved the Department \$56 million by preventing duplicate and/or inappropriate claim payments. In FY86 the Department will achieve incremental MMIS savings as a result of edit enhancements, including duplicate checking, incompatibility audits and frequency edits. This will bring the annual savings from MMIS up to \$64 million annually. During FY87 the Department will achieve an additional \$4.6 million due to annualization of FY86 edit changes.

Acute Hospital Pre-Admission
Screening

2.5

As part of an effort to better manage the fee-for-service component of the Medicaid program, the Department is developing a hospital pre-admission screening initiative. Many other health insurers have already begun using pre-admission screening as a management

INITIATIVE

Acute Hospital Pre-Admission Screening (cont.)

DESCRIPTION

tool. The Department is considering conducting pre-admission screening for all elective acute hospital procedures, excluding obstetrics and substance abuse admissions. Initial work on the program suggests that it would review the medical necessity for an admission and the appropriateness of the proposed admission or procedure to the treatment setting.

Acute hospital inpatient expenditures in FY87 will total about 20% of the Medicaid budget. Preliminary data indicate that the pre-admission screening program could eliminate 2 to 4% of annual hospital expenditures by eliminating inappropriate admissions or, more likely, directing admissions to more appropriate treatment settings. The savings of \$2.5 million projected from this initiative are less than half of those which elimination of even 2% of inpatient spending would produce. The agency has estimated savings conservatively in order to provide adequate implementation time and to reflect the fact that the program will include careful safeguards to protect recipient access to necessary care.

A new generic drug law was signed into law in December, 1985 and will become effective on 7/1/86. This law provides that all pharmacists must issue the less costly generic drug instead of the more expensive

2.0

Legislation

PROJECTED
FY87 SAVINGS
(\$M)

INITIATIVE

DESCRIPTION

Legislation (cont.)

brand name drug unless otherwise instructed by the prescribing physician. In FY87, projected pharmacy expenditures total \$71 million. It is estimated that the new Law will produce savings of \$2 million through a greater proportion of Medicaid prescriptions being filled with generic drugs.

Chapter 372

1.5

As per the original Ch. 372 agreement (and subsequent amendments), Medicaid will obtain an additional 1% productivity savings in hospital rate year 1986 (October 1, 1985-September 30, 1986). The last quarter of hospital rate year 1986 (July 1, 1986-September 30, 1986) is within state fiscal year 1987. A 1% savings on these expenses is worth \$1.5 million.

The productivity factor serves to decrease the growth in acute hospital expenditures to a level slightly below that required for a hospital to receive full reimbursement for inflation and new costs, such as those for the provision of new services. The intent of the productivity factor is to motivate hospitals to identify inefficiencies and reduce unnecessary costs.

Total FY87 Incremental
Medicaid Savings

42.25

MEDICAID SAVINGS, FY82-FY87 (\$M)

<u>Fiscal Year</u>	<u>Incremental</u>	<u>Total Savings Reduction In Expenditure Base</u>	<u>Cumulative</u>
1982	11	11	11
1983	21	32	43
1984	74*	106	149
1985	49**	155	304
1986 (projected)	65	220	524
1987 (projected)	42	262	786

Incremental savings represent new savings in a particular fiscal year, over and above the amount saved in the previous year. Incremental savings essentially indicate how much money the Department did not have to spend in the specific fiscal year the new savings were realized. It is critical to note that in order to obtain credit for new savings, the Department must first ensure that savings already in the base are realized again. The Department must continue to manage its savings base even while adding to it each year to control new inflation and program costs.

Perhaps the most important indicator is the total savings reduction in the expenditure base, which represents the sum of the annual incremental savings since the inception of the savings agenda. This indicator shows how much more money would have been needed in a particular fiscal year if the savings agenda had not been implemented. In the absence of the savings agenda, the Medicaid program would have required an additional \$220 million in the FY86 budget. In other words, \$220 million in unnecessary costs will have been eliminated from the Medicaid program from FY82 through FY86.

Cumulative total savings represent the total value of savings realized since the inception of the agenda. This is different from the previous indicator in that it reflects recurring savings; that is, by the end of FY84, the FY82 incremental savings of \$11 million has recurred 3 times for a cumulative total savings through FY84 of \$33 million (unadjusted for inflation); the FY83 incremental savings of \$21 million has recurred twice for a cumulative total savings through FY84 of \$42 million; and the FY84 incremental savings of \$74 million has occurred once for a cumulative total savings of \$74 million. The sum of these totals equals \$149 million.

* Net of \$15 million for unanticipated Ch. 372 hospital savings in FY84.

** Net of \$10 million for residual unanticipated Ch. 372 hospital savings in FY85.

BACKGROUND INFORMATION TO SUPPORT FY87 BUDGET REQUEST

The preceding discussion summarized the Department's FY84 through FY86 Medicaid savings and program development. This section will provide background information on the operation of the Commonwealth's Medicaid program and additional documentation to support the FY87 request, including:

- o a discussion of Medicaid expenditure trends and summary of the factors driving the budget;
- o a discussion of eligibility categories and presentation of historical and projected caseload data;
- o a discussion of utilization problems and a proposed strategy to address these problems;
- o a discussion of caring for the elderly in Massachusetts; and
- o an explanation of key provider reimbursement issues.

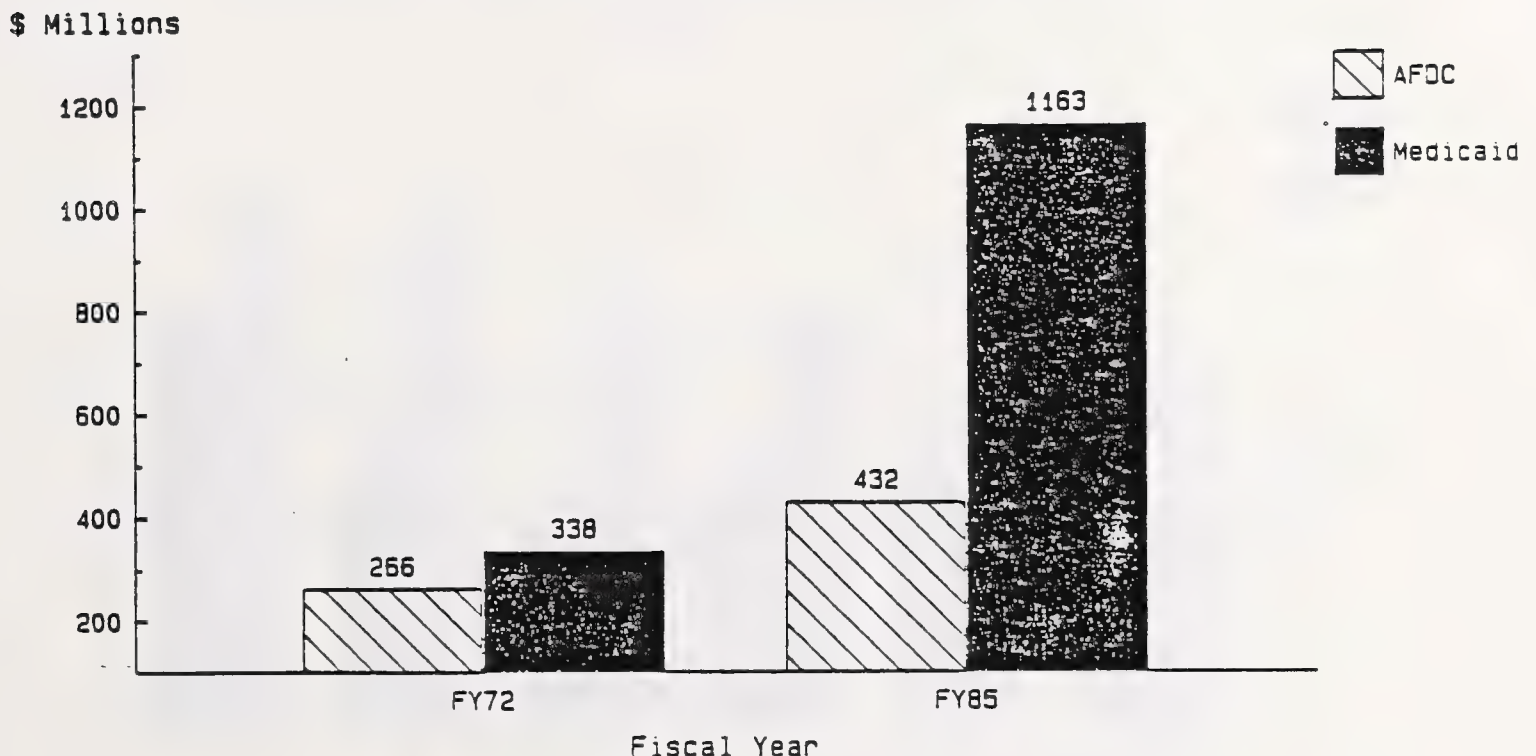
GROWTH IN MEDICAID EXPENDITURES

With aggregate expenditures for the Medicaid program in FY87 projected at \$1.24 billion, Medicaid is the largest single item in the state's budget. Indeed, in each fiscal year since the early 1970's Medicaid has accounted for between 13% and 15% of the total state budget. In federal fiscal year 1984, Massachusetts ranked seventh in the nation in total Medicaid payments.

A number of measures can be used to analyze the growth in Medicaid expenditures. Aggregate expenditures in current dollars is perhaps the most common indicator. This measure suggests that Medicaid spending has grown substantially over the past 13 years. Medicaid expenditures grew from about \$338 million in FY72 to about \$1,163 million in FY85, or approximately 244%. The causes of this growth in current dollar Medicaid expenditures are presented in the next section.

Another measure of the increase in Medicaid spending is a comparison of the rate of expenditure growth of Medicaid and AFDC, the state's two largest entitlement programs. Starting from essentially a comparable base in FY72, the chart below indicates that AFDC spending increased by 62% through FY85 while Medicaid spending more than doubled in the same period. In aggregate current dollars, AFDC spending increased by \$166 million and Medicaid spending increased by \$825 million in the FY72 to FY85 period.

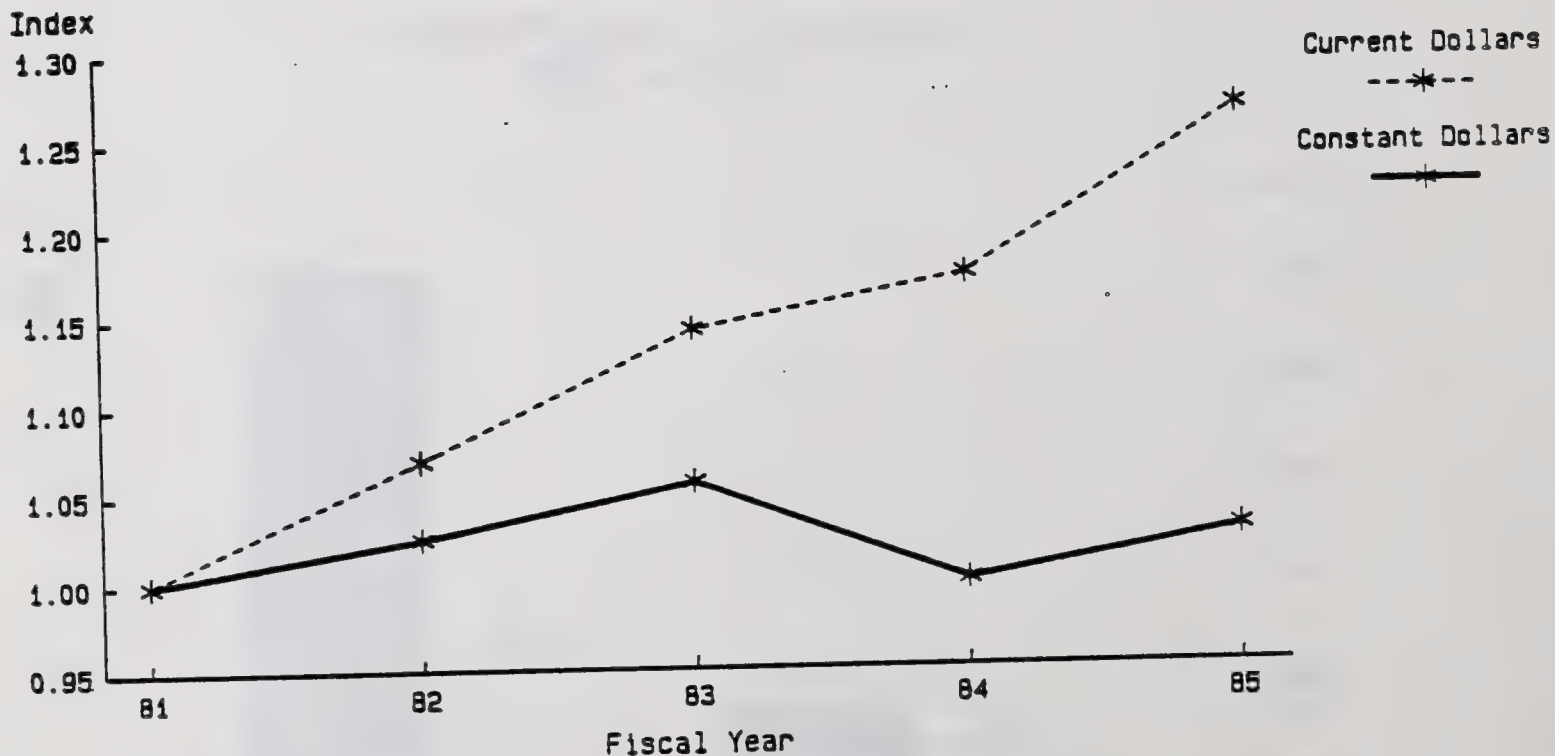
MEDICAID V AFDC SPENDING FY72 - FY85



Since increases in current dollar Medicaid expenditures are, in large part, determined by price inflation and changes in caseload, adjusting aggregate expenditures for these factors is yet another way to compare spending patterns over time. This measure is particularly relevant for analyzing Medicaid expenditure trends given the typical increases in medical care prices (averaging about 10% annually since FY74) and variations in caseload. By adjusting for the fiscal impact of medical care inflation and changes in caseload, a trend comparison of spending changes in real terms (constant dollar buying power) for the Medicaid budget is possible.

While the available data restricts a comparison to the FY81-FY85 period, the pattern of expenditures for this measure, as indicated in the chart below, suggests that through its Medicaid savings, the Department was able to alter the trend of substantial increases in real spending for Medicaid. Specifically, Medicaid expenditures, adjusted for medical care inflation and changes in caseload, actually declined by about 3% over the last two years. Moreover, the average annual rate of growth in constant dollars from 1981 to 1985 was a modest 0.7%.

MEDICAID EXPENDITURES CURRENT V. CONSTANT DOLLARS



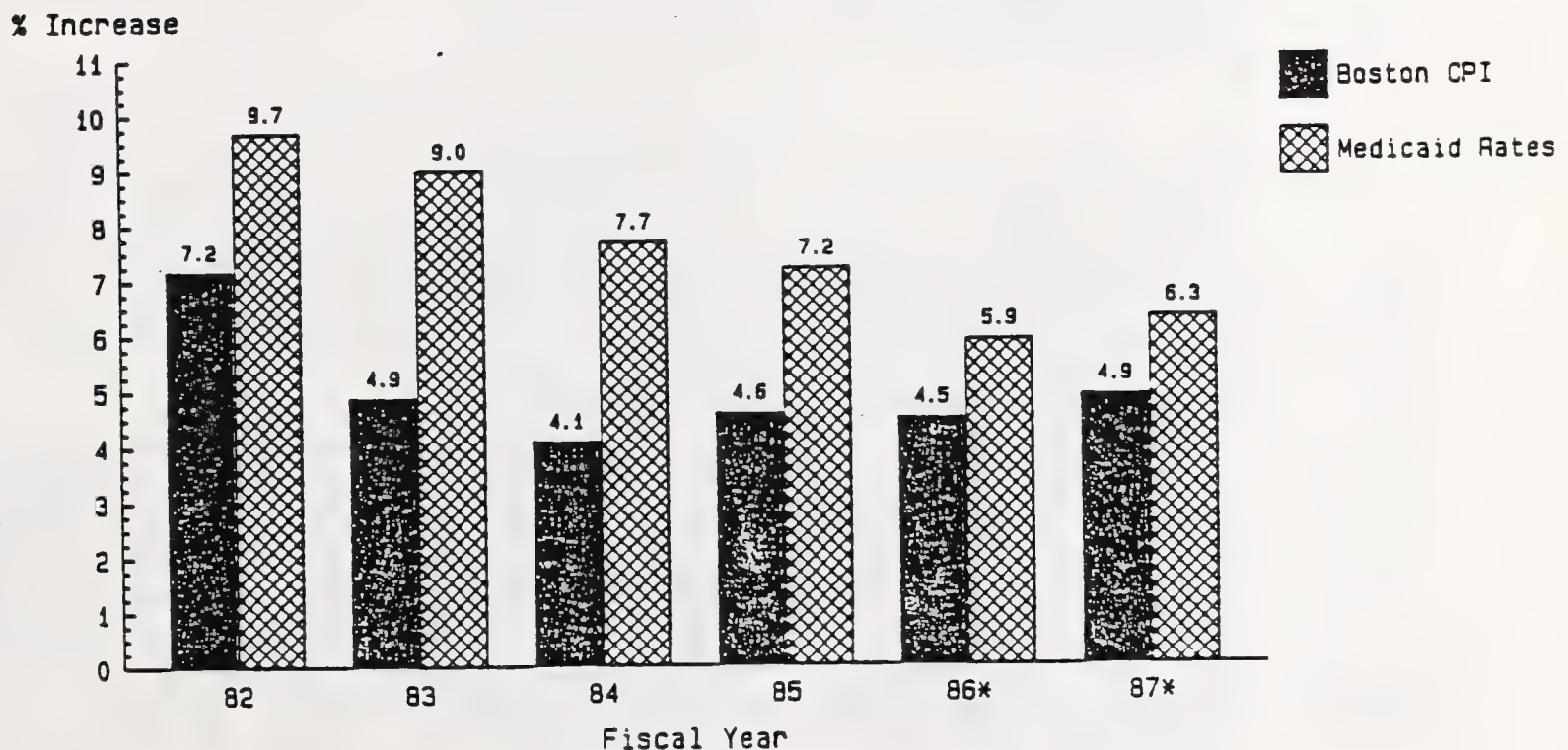
CAUSES OF GROWTH IN MEDICAID SPENDING

A number of fundamental factors drive up Medicaid spending. These factors, some of which are described in more detail in subsequent sections, are:

- o the rates paid to medical providers.

The predominant reimbursement methodology used to determine Medicaid provider reimbursement is cost based: this type of system recognizes as reimbursable virtually all costs that providers incur in delivering care to recipients. At first examination, cost-based reimbursement seems entirely reasonable. The problem with the system is the relative absence of incentives to contain costs or to promote efficiency. In fact, because future reimbursement rates are a function of costs incurred in an earlier base year, providers are encouraged to spend as much as possible. Despite continuing efforts to control costs by both the Department and the Rate Setting Commission, the program has experienced annual percentage increases in provider rates which not only equal but exceed inflation in the national economy. The chart below compares the Massachusetts Medicaid provider rate of inflation with the Boston consumer price index, which measures prices of a fixed set of consumer goods and services. Because spending in the Medicaid program is projected to exceed \$1.2 billion in FY86, the fiscal impact of the 6.3% inflation rate projected for FY87 is in excess of \$75 million.

**Boston Consumer Price Index Compared to
Medicaid Weighted Average Rate Increase
FY82-FY87**



* Projected

- o the amount of services used.

A Medicaid card provides a Massachusetts recipient with essentially unlimited use of what is perhaps the nation's most sophisticated and expensive health care system. Recipients and providers, neither of whom have any fiscal responsibility for these decisions, decide which services to utilize and provide. With very few exceptions, the present fee-for-service system leaves the Department unable to ensure that recipients obtain only necessary care and that they obtain that care in the least expensive setting appropriate for their conditions. Indeed, the fee-for-service system encourages unnecessary and inappropriate utilization: the more, and more expensive, services providers render, the greater their reimbursement. Further, indiscriminate utilization and provision of services has an adverse effect on continuity of care, a key quality-of-care indicator.

- o caseload and the elderly.

The size of the population eligible for Medicaid is another key determinant of Medicaid spending. However, perhaps even more important than the number of eligibles is who those eligibles are. In recent years, the number of people receiving Medicaid cards has declined, but costs have continued to increase. This is because the caseload decline has occurred primarily among families and children. Caseloads in SSI and Medicaid-only categories serving the elderly and disabled have remained relatively stable or in some instances increased. Growth in the state's elderly population and the cost of the medical services for the elderly, have become more important factors in driving up Medicaid expenditures than changes in the overall number of Medicaid eligibles.

The Department's Medicaid program spends over 50% of its budget (about \$630 million in FY85) on care for the elderly. Further, between 1970 and 1980, the over-75 population in Massachusetts increased 19% and the over-85 population increased 43%. Given that elderly individuals require on average a considerable amount of medical care, the aging of the population alone will inevitably inflate state Medicaid costs -- despite the program's considerable efforts to control costs.

In addition, there is considerable evidence that many people see Medicaid as an appropriate means of preserving family resources. Many elderly individuals have been able to restructure their finances to qualify for Medicaid coverage, particularly through sale or transfer of property to relatives. Although these financial arrangements often do not violate state law, the end result is the state's assumption of high-cost nursing home and other care for people who are not poor.

o the number of Medicaid providers.

The number and type of providers offering services through the Medicaid program are also factors in determining spending. There are currently about 22,000 providers participating in the program. Participation is voluntary. Most providers meeting federal and state licensure and other standards are likely to be certified to participate after application to the Department since the agency does not make need for an additional provider part of the process of admitting providers to the program.

Most of the state's hospitals and nursing homes participate in the program; participation levels among other provider groups vary. The Department is committed to ensuring client access to all necessary services, and therefore frequently has sought to increase participation among physicians, dentists, and other community-based providers not sufficiently available to the Medicaid recipients in some parts of the state. Increased participation by these providers has an impact on expenditures, but that impact may in fact be favorable if greater availability of primary services makes it unnecessary for clients to obtain services in more expensive settings such as hospital outpatient departments and encourages clients to use preventive health care. However, cost-effectiveness arguments may be less readily applicable to some other provider types. For instance, the number of mental health clinics participating in Medicaid rose from 70 in 1980 to 122 in 1985; in part because of this increase, spending for that provider type rose by almost 150% in the same time period.

The nursing home bed supply, an even more important factor in Medicaid spending since the Department pays for over 70% of the state's nursing home beds, had been essentially stable for several years but now appears likely to begin increasing. The number of new beds anticipated will result in \$35 million to \$40 million in new Medicaid spending for nursing homes over the next fiscal years.

o technological advances.

Technological advances -- including the development of more refined diagnostic equipment (e.g., the recent development of the nuclear magnetic resonance device), the formulation of drugs which decrease the likelihood of rejection of transplanted organs, and the application of new medical procedures -- have resulted in increased life expectancies for the general population and for severely disabled children and chronically ill elderly individuals. These services and attendant follow-up care require resources beyond the means of even affluent individuals. Transplants provide the most vivid example of this phenomenon. For instance, a recent Department of Public Health Task Force report projected that average first year medical care costs for an individual who receives a liver transplantation is \$230,000. Because of the understandable reluctance of other insurers to

fund these procedures, especially while they are still experimental, those needing transplants and other sophisticated care look to the state for assistance in covering the cost of these procedures. In order to limit the disproportionate impact of the new technology on the state's already limited human services resources, it is critical that the cost of care for nonindigent patients be shared by all the principal payors in the hospital reimbursement system. Further, every effort should be made to use the new procedures and technologies as cost-effectively as possible by avoiding unnecessary duplication of services and carefully designing payment methodologies.

CASELOAD

INTRODUCTION

Medicaid makes necessary and high-quality care available to people whose incomes and resources are below a level established by the individual states (within federal guidelines). As the discussion below indicates, the Massachusetts Medicaid program provided medical coverage to an average of 434,000 low-income individuals per month in the first half of FY86.

The following section presents basic information on the Medicaid caseload, including:

- o the population which participates in Medicaid;
- o the distribution of resources and expenditures among Medicaid participants; and
- o the key eligibility policies which define who is entitled to receive health care through Medicaid.

Caseload Overview

In the first half of FY86, enrollment in the Massachusetts Medicaid program averaged about 260,500 cases per month. Since each case consists of one or more recipients, the actual number of enrolled individuals was approximately 434,000. While these enrolled low-income elderly, children, disabled, and working poor families were eligible for necessary medical coverage, not all recipients used services each month: monthly Medicaid utilization rates for families and children ranged from 40% to 60%, while rates for aged and elderly recipients on Supplemental Security Income ranged from 70% to 80%, and rates for elderly and disabled on Medicaid-only ranged from 80% to 100%.

The Medicaid caseload consists of two groups of recipients: the categorically needy and the medically needy.

- o The categorically needy, who represent about 75% of all Medicaid cases, are eligible to receive cash assistance from either the Aid to Families with Dependent Children (AFDC) program, the Supplemental Security Income (SSI) program, or the Refugee Resettlement program. In the first half of FY86, the average monthly categorically needy caseload was about 195,000; the average monthly recipient count for this group was about 351,000.
- o The medically needy (medical coverage only) are individuals and families who are financially ineligible for cash assistance, but whose income and resources are insufficient to meet their medical needs. (Serving the medically needy is an option that states can exercise under the Medicaid program. Massachusetts is one of 31 states which exercise this option.) Approximately one-half of the medically needy caseload consists of poor families and individuals whose income and resources are within prescribed

eligibility limits. The other half consists of families and individuals who become eligible by participating in Medicaid as spend-down cases. These individuals qualify for Medicaid because they incur expenses which reduce their income below the applicable medically-needy income standard. In the first half of FY86, the average monthly medically-needy caseload was about 65,500, representing 25% of the total Medicaid caseload. The average monthly medically-needy recipient count was approximately 83,000.

FY86 MEDICAID CASELOAD COMPOSITION

<u>Eligibility</u>	<u>Average Monthly Caseload</u>	<u>% of Overall Caseload</u>	<u>Average Monthly Recipient Count</u>	<u>% of Overall Recipient Count</u>
Categorical	195,000	75%	351,000	81%
<u>Medicaid-Only</u>	<u>65,500</u>	<u>25%</u>	<u>83,000</u>	<u>19%</u>
Total	260,500	100%	434,000	100%

A. Categorically-Needy Caseload

The Department provides automatic Medicaid entitlement to recipients who are eligible for one of the categorically needy programs -- AFDC, SSI or RRP.

- o AFDC - Through eligibility for the AFDC program, approximately 85,000 families (238,000 individuals) were automatically entitled to Medicaid coverage in the first half of FY86. Moreover, as an employment incentive, the Department also extends Medicaid coverage for three months to families who become ineligible for AFDC cash benefits because of increased earnings from employment. In the first half of FY86, an average of 470 ex-AFDC cases received extended Medicaid coverage each month. The average annual Medicaid cost per AFDC case, which usually consists of 2.8 recipients, is \$3000.
- o SSI - Eligibility for the SSI program entitles low-income elderly and disabled individuals, 95% of whom reside in the community and 5% of whom are in nursing homes or chronic disease and rehabilitation hospitals, to obtain Medicaid. In the first half of FY86 a monthly average of approximately 107,300 individuals were entitled to Medicaid through the SSI-Aged and SSI-Disabled programs.
- o Refugee Resettlement Program (RRP) - A small proportion of the caseload (1%) consists of refugees eligible for the RRP. In the first half of FY86, an average of 2,350 cases were entitled to Medicaid through the federally funded RRP.

Unlike the medically needy (discussed below), the categorically eligible receive cash grants in addition to entitlement to Medicaid.

B. Medicaid-Only Caseload

The general intent of the Medicaid-only (MA-only) program is to provide Medicaid benefits to individuals and families who are financially ineligible for cash assistance, but whose income and resources are insufficient to meet their medical needs. These individuals are considered medically indigent. The MA-only categories of assistance are classified according to age, disability, and family composition. The categories include: MA-OAA (elderly), MA-DA (disabled), MA-AFDC (families), and MA-UN21 (children).

- o Medicaid-Old Age Assistance (MA-OAA) - Individuals who qualify for MA-OAA must be at least 65 years old and meet MA-only income and asset requirements. The MA-OAA recipients constitute the largest portion of the MA-only program, both in terms of caseload and expenditures. The average monthly MA-OAA caseload for the first half of FY86 was about 38,500, representing 15% of the total Medicaid caseload. However, because a large proportion of the MA-OAA caseload receives costly institutional long-term care, 43% of the Medicaid budget (or about \$500 million in FY85) is spent for services provided to these recipients. The median length of stay on Medicaid for these recipients is 2.5 years.

The characteristics of the MA-OAA caseload are:

- Long-Term Care - In the first half of FY86, approximately 30,000 or 78% of the recipients on the MA-OAA caseload resided in institutions such as nursing homes and chronic disease and rehabilitation hospitals. While some of these individuals moved to nursing homes where Medicaid would pay because they could no longer afford their medical bills in the community, others entered nursing homes privately and applied for Medicaid when they exhausted their own resources. The large proportion of recipients receiving institutional long-term care explains the high average Medicaid cost per MA-OAA case, which is about \$13,600 per year.

Of the 30,000 Medicaid recipients in institutional long-term care settings, virtually all (28,500) have monthly income in excess of the \$55 personal needs allowance (PNA), which also serves as the Medicaid income-eligibility standard for institutional long-term care cases. These individuals, institutional spend-down cases, contribute the difference between their income and the \$55 PNA to the cost of their care. On average, recipients contribute about \$420 per month (or \$5,000 annually) toward the cost of their care, which usually exceeds \$1,600 per month (or \$19,000 annually).

- Community Care - In the first half of FY86, approximately 8,500 (22%) of the recipients in the MA-OAA caseload resided

in the community. Of these recipients, 7,700 (91%) have income within the MA-only eligibility limits, while 800 (9%) "spend-down" income in excess of the eligibility standards before becoming eligible to receive Medicaid benefits.

There is a significant difference between spend-down clients who reside in institutional long-term care settings and those who reside in the community. Specifically, institutional long-term care recipients contribute their monthly income in excess of the \$55 eligibility standard (PNA) toward the cost of their care, while community recipients must "spend-down" or incur medical bills worth six times their excess monthly income within a six-month period before they become eligible for Medicaid benefits.

- The Pickle Amendment - Included in the MA-OAA caseload are about 4,500 former SSI recipients (or 12% of the total number of individuals) who qualify for Medicaid benefits under the Pickle Amendment to the Social Security Act of 1977. The so-called "Pickle cases" are former SSI recipients who also had Social Security income, and who received Social Security cost-of-living increases sufficient to make them ineligible for SSI. The Pickle Amendment allows them to continue to receive Medicaid benefits.
- o Medicaid-Disabled (MA-DA) - In the first half of FY86 a monthly average of 8,600 disabled children and adults received MA-DA coverage. To qualify for MA-DA, individuals must meet both the categorical (an individual who is unable to work as a result of a medically determined physical or mental impairment. The disability must be expected to last 12 months) and the MA-only income and asset requirements. As described below, the relatively high average annual cost per MA-DA case, \$11,800, is a function of the high proportion of individuals who receive care in institutional long-term care facilities. The median length of stay on the Medicaid caseload for these recipients is 2 years.
- Long-Term Care - In the first half of FY86, approximately 4,200 (49%) of the MA-DA recipients resided in long-term care facilities including nursing homes, chronic disease and rehabilitation hospitals, and state schools.

Of the 4,200 recipients receiving institutional care, about 3,600 (86%) contribute their monthly income in excess of the \$55 PNA toward the cost of their care. The average monthly recipient contribution is about \$310, or \$3,700 annually.
- Community - In the first half of FY86, approximately 4,400 (51%) MA-DA recipients resided in the community. While 4,000 (91%) of the MA-DA community recipients had income and resources within the prescribed Medicaid-only eligibility limits, 400 (9%) "spent-down" or incurred medical bills equal to the value of their excess income before becoming eligible for Medicaid.

- The Pickle Amendment - Like MA-OAA, MA-DA also includes some former SSI recipients (1,000 or 12% of the MA-DA caseload) who qualify for Medicaid under the Pickle Amendment.
- o MA-AFDC - Most MA-AFDC cases are low-income single-parent families, or families with one or both parents unemployed or incapacitated. During the first half of FY86, the caseload averaged 8,600 cases; each case contained an average of 2.6 recipients. The total number of recipients was 22,400. MA-AFDC cases have characteristics similar to their categorically needy counterparts on AFDC, except that their income and resources are too high to qualify them for cash assistance.

A substantial portion of the MA-AFDC caseload also includes cases that, as a result of the federal Omnibus Budget Reconciliation Act of 1981, are no longer eligible for cash assistance under the AFDC program. Among these cases are single-parent families with children 18 to 21 years of age, and families with stepparent income.

Relative to the elderly and disabled individuals on the MA-only caseload, the average cost per MA-AFDC case, about \$2,900 per year, is low. This is attributable primarily to the fact that, unlike the large proportion of elderly (78%) and disabled (49%) MA-only recipients who utilize institutional long-term care, less than 1% of the MA-AFDC caseload requires institutionalization. The families and children on MA-AFDC generally use Medicaid on an infrequent basis to pay for routine, preventive, and emergency medical services. Most MA-AFDC recipients (84%) remain eligible for 1 year or less. The median length of stay is only 2 months.

- o Medicaid-Under 21 (MA-UN21) - This category consists primarily of children of low-income intact families whose income and assets are below the Medicaid income standard. In the first half of FY86, the MA-UN21 caseload averaged 9,800 cases, which contained an average of 1.4 recipients per case. MA-UN21 recipients include the children of some working poor parents who do not receive other cash assistance. About 30% of the MA-UN21 recipients live in households that receive General Relief assistance. Most (75%) MA-UN21 cases remain on the caseload for one year or less. The median length of stay is 6 months.

The average annual cost per MA-UN21 case is \$1,900. Overall, the MA-UN21 and MA-AFDC caseloads display similar utilization characteristics. Of the total Medicaid resources used by both MA-AFDC and MA-UN21 cases, approximately 45% is spent on acute hospital inpatient care, 25% on acute hospital outpatient care, 10% on physician services, and the remainder on other services.

CHARACTERISTICS OF THE FY86 MEDICAID CASELOAD

Indicator	Categorically Eligible				Medically Needy			
	Refugee	SSI-Aged	AFDC	SSI-Disabled	MA-OAA	MA-AFDC	MA-DA	MA-UN21
<u>Demographic Characteristics</u>								
o Average case count	2,350	53,200	85,200	54,100	38,500	8,600	8,600	9,800
o Average recipient count	5,900	53,200	237,800	54,100	38,500	22,400	8,600	13,300
o Average recipients/case	2.5	1	2.8	1	1	2.6	1	1.4
o Percent female	N/A	80%	66%	57%	79%	65%	49%	59%
o Percent of caseload which spends-down	N/A	N/A	N/A	N/A	77%	2%	49%	2%
<u>Utilization Characteristics</u>								
o Percent in long-term care	N/A	5%	1%	5%	78%	1%	49%	1%
o Percent of recipients utilizing services each month	N/A	70-80%	40-60%	70-80%	80-100%	40-60%	80-100%	40-60%
o Average cost/case	\$2,300	\$2,100	\$3,000	\$3,900	\$13,600	\$2,900	\$11,800	\$1,900
o Median cost/case	N/A	\$600	\$900	\$900	\$10,000	\$800	\$1,500	\$400
o Median length of stay on Medicaid-only caseload	16 mos.	N/A	9 mos.	N/A.	30 mos.	2 mos.	24 mos.	6 mos.

COST PER CASE

Average cost per case is a common measure of the usual value of the medical benefits Medicaid families and individuals receive. However, because an average ignores the distribution of expenditures among the caseload and is often skewed by extreme values, it does not necessarily provide an accurate indicator of the "benefits package" provided to the typical Medicaid case. For this reason the median cost per case, because it adjusts for the small number of atypical high-cost cases that skew the average, may be a more appropriate statistical measure of the worth of medical benefits to typical clients.

As the table on the previous page displays, average and median cost per case vary widely within and among the categories of assistance. The characteristics of the cases in each category (age, family composition, and medical needs), many of which were highlighted above, are related to these cost variations. Among the more important relationships are:

- o The average annual Medicaid costs per elderly (\$13,600) and disabled (\$11,800) recipient on the Medicaid-only caseload are considerably higher than those of the other categories. By comparison, the average annual Medicaid costs per SSI-eligible elderly and disabled recipient are \$2,100 and \$3,900, respectively. This dramatic difference is a direct function of the proportion of the respective caseloads residing in long-term care institutions.
- o The average annual cost per case for children and families on AFDC is \$3,000. (Given that each case has 2.8 recipients, the average cost per AFDC recipient is about \$1,000.) These individuals tend to require less and a different type of medical care than the elderly and disabled. AFDC recipients primarily utilize ambulatory pediatric care and acute hospital maternity care, services which are generally more episodic and less costly than institutional long-term care. Correspondingly, the average annual cost for AFDC recipients is lower than the average annual cost for the elderly and for the disabled.

Perhaps more striking than the average annual cost is the distribution of medical costs within the AFDC category. In particular, the median cost per AFDC case is \$900, less than one-third the AFDC average of \$3,000. This indicates that the costs of a small number of catastrophically ill AFDC recipients skew the average and that the bulk of the caseload utilizes considerably less medical care than the average implies. Indeed, data show that about 7% of the recipients on the AFDC caseload utilizes about half of the medical care resources consumed by the AFDC population annually. The Department recognizes that this type of relationship -- a small proportion of recipients using a disproportionate amount of resources -- exists across all payors. However, to some extent this utilization phenomenon results from the current fee-for-service delivery system (no incentives to promote cost control, and insufficient provision of primary care). The Department therefore believes that it is essential to develop and implement alternatives to the traditional

Medicaid fee-for-service delivery system. The special report on HEALTH CHOICES FOR FAMILIES AND CHILDREN, located following the Medicaid narrative, provides a detailed discussion of the Department's proposal to begin to restructure the existing Medicaid program.

MEDICAID CASELOAD TRENDS

As the graph on the next page shows, after steadily declining from FY80 through FY83, the aggregate Medicaid caseload has stabilized.

The following section provides a summary of the major factors, including federal and state eligibility criteria, that have shaped and will continue to influence the Medicaid caseload.

A. Through FY83

National statistics show that the Massachusetts Medicaid program's eligibility standards and benefit package are relatively generous compared with those of other states, thereby offering greater protection for the Commonwealth's low-income population. However, changes at the federal level have significantly reduced the caseload eligible for Medicaid through eligibility for AFDC. Specifically, by 1983, provisions of the federal Omnibus Budget Reconciliation Act (OBRA) of 1981 had decreased the AFDC caseload by 30,000 cases in Massachusetts over the first two years of the new legislation.

The majority of the cases which lost categorical eligibility did not obtain coverage through the Medicaid-only program. In fact, over the period 1975-1983, the caseload for the Medicaid-only program dropped by about 14,000 cases, representing an overall decline of 18%. This was attributable largely to the fact that the income eligibility standards were not adjusted regularly to reflect rising wages and prices. Between 1975 and 1983 the Massachusetts Medicaid-only income standard went from 28% above to 21% below the federal poverty standard for individual filing units, and from 9% above to 35% below the poverty standard for families of 3.

As a consequence, it became particularly difficult for the working poor to qualify for Medicaid. The MA-Under 21 caseload dropped by 57% in this time period; MA-AFDC dropped by nearly 13%. Even those families whose wage earners held relatively low-paying jobs had income in excess of the standards. Those families often did not have health insurance and frequently did not obtain preventive care. When a family member became ill, the family usually had to obtain free care at a municipal hospital or quit working and return to AFDC.

The lack of any substantial increase in the eligibility standards also created problems for elderly and disabled individuals living in the community. Those who had too large an income to qualify for SSI were often not eligible for MA-only. Indeed, the MA-only standards were lower than the SSI income standards. This was a problem because the small income these individuals relied upon was often not adequate to cover the basic costs of food, shelter, and medical care. Some

elderly and disabled individuals had no other alternative but to move into nursing homes in order to obtain Medicaid. The narrative section on caring for the elderly describes this situation in more detail.

B. FY84

Although there was no change in the MA-only income standards in FY84, the MA-only caseload increased, principally because of the Massachusetts Association for Older Americans (MAOA) court decision, which became effective in July 1983.

The MAOA decision requires the Department to continue Medicaid benefits until the Department can conduct a separate redetermination of eligibility for Medicaid-only recipients who lose their AFDC or SSI cash benefits. The FY84 average monthly caseload (68,863) was 10% higher than it was in FY83. This increase occurred because the steady addition of categorical cases which closed each month and became eligible for Medicaid-only were initially not redetermined promptly due to competing administrative resource demands. During the first year of MAOA, the Department's primary administrative eligibility goal was to reduce the AFDC and Medicaid error rates. Progress on these problems enabled the Department to commit resources, in FY85, to the MAOA backlog.

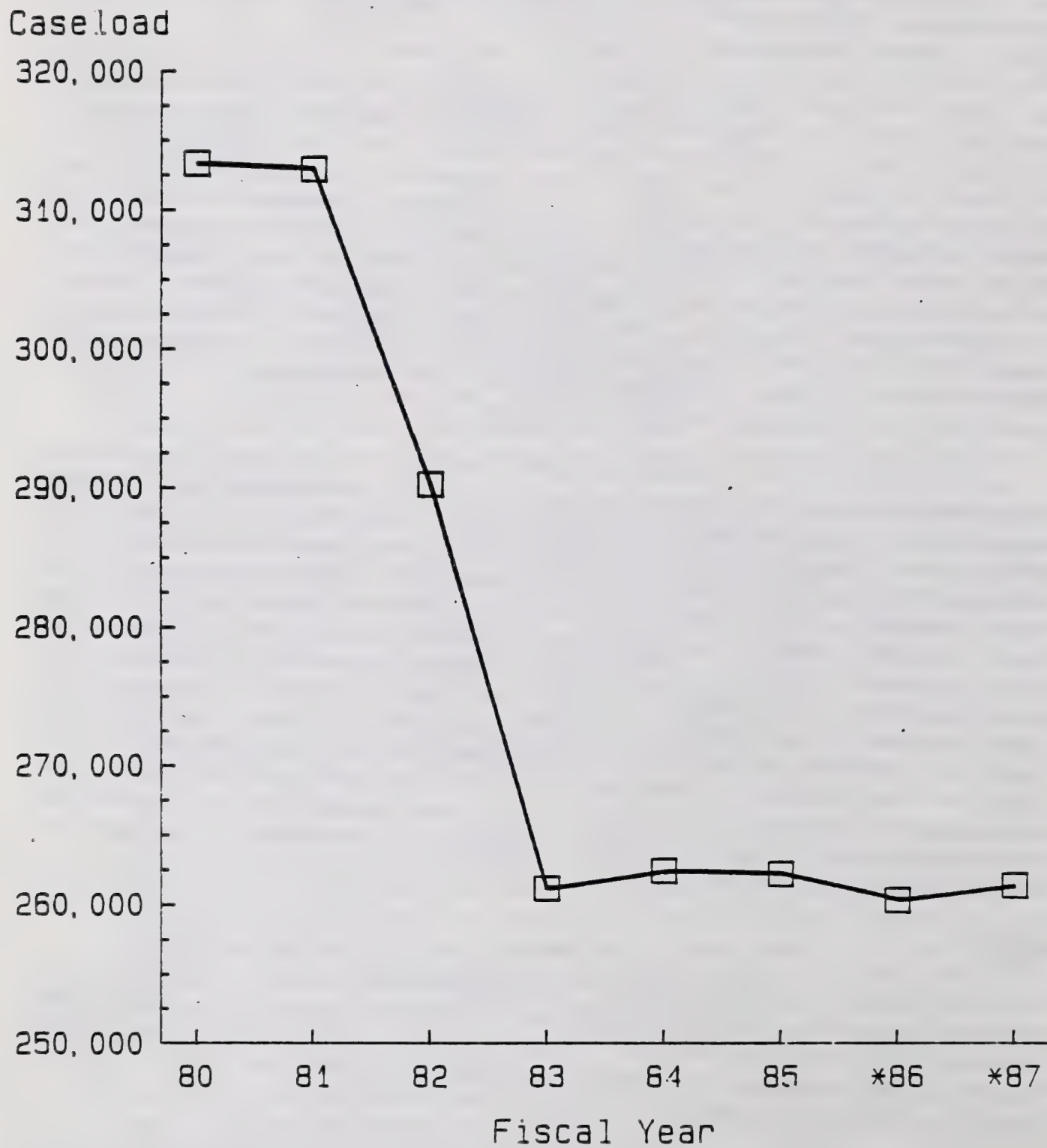
In mid-September 1984, the Department established a centralized MAOA redetermination unit designed to expedite the redetermination of MAOA cases. The caseload declined significantly in the second quarter of FY85 after the plan's implementation, indicating that the MAOA backlog of ineligible cases had been resolved. Implementation of the court decision does benefit many recipients by ensuring that they have adequate health care coverage for at least one or two months until they undergo a separate Medicaid-only eligibility determination. In addition, MAOA guarantees continuing coverage to families and individuals who are found eligible for Medicaid-only upon a separate eligibility determination. Approximately 2,500 families and children cases and 800 elderly and disabled cases lose categorical eligibility each month and are automatically transferred to Medicaid-only due to the MAOA decision. More than 10% remain on MA-only after redetermination.

C. FY85

In FY85, in recognition of the problems created by the low eligibility standards, the legislature authorized and the Department implemented two initiatives which enabled about 2,500 additional elderly and disabled individuals, and working poor families to secure health care through Medicaid. The initiatives were:

- o a 4% AFDC payment-standard increase in FY85, which enabled 600 additional elderly and disabled individuals and 500 additional families to receive Medicaid; and

AVERAGE MEDICAID CASELOAD FY80-FY87



* Projected

- o a 10% Medicaid-only income-standard increase for filing units of 3 through 10, which added 1,400 working poor families to the Medicaid caseload.

D. FY86 and FY87 Initiatives

In FY86 and FY87, several additional initiatives have been implemented or proposed. These changes will allow about 700 low-income elderly or disabled individuals, and 3,000 working poor families an opportunity to receive Medicaid. Specifically:

- o a 9% AFDC payment-standard increase in FY86, which is expected to enable 800 additional families to receive Medicaid;
- o a 15-month extension of Medicaid coverage to about 1,000 families who would have become ineligible for AFDC due to an OBRA eligibility policy change. A 9-month extension is required by the federal Deficit Reduction Act of 1984; the Commonwealth has chosen the option to extend the benefit by an additional 6 months, to 15 months;
- o a legislative initiative to raise the Medicaid-only income standard for filing units of one, by making it equal to the SSI payment standard for disabled individuals living alone in the community. This raised the monthly income standard from \$355 to \$440 on July 1, 1985. (This standard was further increased to \$451 on January 1, 1986, as a result of the SSI cost-of-living increase.) This change is expected to result in 700 additional elderly and disabled individuals and 300 additional families and children becoming eligible for Medicaid-only;
- o a proposed 10% AFDC payment-standard increase in FY87, which would enable 900 additional families and children to receive Medicaid.

<u>Change in Medicaid-Only Caseload, FY83 - FY86</u>			
<u>MA-only Category</u>	<u>FY83</u>	<u>FY86</u>	<u>% Change</u>
MA-OAA	39,589	38,461	(2.8%)
MA-AFDC	5,596	8,640	54.4%
MA-DA	7,527	8,570	13.9%
MA-UN21	7,916	9,819	24.0%
TOTAL	60,628	65,490	8.0%

UTILIZATION

Introduction

Another important factor affecting the level of Medicaid spending is utilization of resources; that is, the amount and intensity of health care resources used by each recipient. In an effort to ensure quality and to control spending, private payors, business, government and health care professionals have directed considerable attention over the last decade to the issue of necessity and appropriateness of service. Initially, government and private third-party payors established basic quality assurance programs, concentrating primarily on the amount of care provided in acute hospitals. Many have questioned the economic and programmatic utility of these programs, arguing that the criteria used to evaluate prescribed medical regimens were so broad as to result in approval of many unjustified procedures. Moreover, the rudimentary standards precluded evaluation of the relative merit of medical procedures, or, in basic terms, whether the benefits exceeded the costs.

As a result, health care professionals in recent years have attempted to refine the methods used to assess quality and appropriateness of care. In particular, much scrutiny has been focused on provider practice patterns to determine whether variances in medical treatment exist for comparable diagnoses in similar populations. Preliminary findings have documented wide utilization differences for certain diagnoses, primarily for hospital surgical procedures. To date, comparative analyses have concentrated on hospital procedures, although it is expected that utilization differences also exist for non-hospital procedures.

Although it is generally accepted that for many procedures there is a certain amount of discretion that underlies medical practice, these variances in treatment for similar diagnoses have spurred health insurance payors to refine their utilization review programs and to shape their coverage policies to promote a more judicious, less costly distribution of resources. For instance, some insurers have established second-opinion programs, which require a second surgeon's consent in order for certain elective procedures to be reimbursed. Moreover, increasing numbers of insurers and businesses are including in their benefit plans specific incentives to encourage substitution of less resource-intensive treatment protocols for certain procedures traditionally performed in institutions. One example is coverage of certain elective surgical procedures in outpatient settings, thus avoiding the room, board, and other costs that would be incurred if the individual were to receive inpatient care in a hospital.

This is not to argue that the practice of medicine or the number of procedures prescribed by each physician should be subject to uniform, rigid standards. Clearly, continued technological progress and the uncertain etiology of many illnesses defy predetermined treatment regimens. Nonetheless, it does not follow that utilization decisions should be a sacrosanct issue, the sole province of the provider community. As health care services continue to consume a larger share of business', and state and federal governments' budgets, these institutions will have little choice but to continue to promote and establish initia-

tives to moderate health care spending growth. To date, unlike the business sector, the state's cost-containment strategies have focused primarily on rate control, and utilization control has received relatively little attention. Utilization, the per capita consumption of services, is one area that requires more scrutiny for the state to control Medicaid costs.

This section of the Medicaid narrative describes the existing Medicaid utilization review program and the strategy for FY87 and beyond.

Present Utilization Review System

The Medicaid program seeks to meet recipient health care needs while ensuring that recipients obtain only necessary services, and that they obtain that care in a cost-effective setting. Despite the Department's best efforts to monitor utilization through the activities highlighted below, the program, in its present form, does not satisfactorily meet all of these objectives. Every month, each of the state's more than 260,000 Medicaid cases (434,000 recipients) receives a paper Medicaid identification card. These cards provide recipients with virtually unlimited access, free of charge, to the state's extraordinary health care system. Using the card, recipients may obtain almost any service in almost any health care facility in Massachusetts. Providers then bill the Department for each service the recipients obtain. As this description suggests, the program's present structure:

- o with few exceptions, does not ensure continuity of care. Indeed, recipients may receive treatment for routine care from many different practitioners, rather than from a personal physician.
- o permits recipients to obtain services in a setting of the recipients' choosing, regardless of expense.
- o pays providers for each service they deliver. This fee-for-service system at least implicitly encourages providers to deliver more, and more intensive, services than necessary as a means of increasing their reimbursement.
- o does not confine the purchase of Medicaid services to the most economical providers available, despite wide variations in charges for similar services within some provider groups, particularly hospitals.
- o does not limit the number of providers in the program. In most provider types, any provider of any reimbursable service who meets Medicaid certification requirements may join the program, regardless of whether there is a need for additional service of that type.

Thus, the Department pays for recipient and provider decisions about the use of services but has little influence over those decisions, nor the ability to ensure that recipients receive continuity of care, a key indicator of quality. The current system does not ensure that Medicaid recipients will have the opportunity to develop a personal relationship with a physician who assumes lead responsibility for their medical care, by delivering primary health services and making appropriate referrals for specialty care. In the absence of a primary care physician, recipients often obtain more services and more costly services in more expensive settings (i.e., acute hospital outpatient departments and/or emergency rooms) than the recipients' conditions require. In certain other situations, primarily for low-income elderly in nursing homes, the absence of primary care treatment could result in failure to detect diseases at a stage where basic treatment could prevent serious illness. The following examples are illustrative rather than exhaustive:

- o A state Department of Public Health study (1983) found that about 42% of the patients in chronic disease and rehabilitation hospitals (CDRH) did not require this level of care, but should be treated in less intensive facilities or in the community. Given the significant variance between the average CDRH per diem rate and the average skilled or intermediate nursing facility per diem rate, it seems likely that the state is spending at least \$10 million per year for unnecessary care in CDRHs.
- o A Department study conducted in 1983 documented that Medicaid often pays for the site where the health care is delivered rather than for the medical service itself. In the case of some hospital facilities, outpatient department (OPD) charges can be as much as 500% more than charges for the same service delivered in a community health center (CHC) or in a freestanding physician's office. The study's findings indicate that considerable savings could be generated, without compromising quality, through implementation of policies that redirect individuals from high-cost OPDs to either lower-cost CHCs or to freestanding physicians' offices.

The high cost of OPD care is due in part to the relatively high overhead of hospital-based care as well as an indirect subsidy for medical training. More importantly, it is due to the irrational fragmentation of care, where there are multiple entry points and unnecessary use of specialty clinics and associated technologies. One study of a large urban teaching hospital documented that on average patients were seen concurrently in 3 or more specialty clinics without adequate coordination and without the knowledge of the primary managing physician. Further, a large proportion of these specialty visits were deemed medically unnecessary.

- o The Department estimates that 5% or more of the acute hospital inpatient days for which the Department pays are not medically necessary. Common examples of medically unnecessary acute hospital inpatient days include: (i) pre-operative days for which preparation for surgery could have been provided

appropriately in an ambulatory care setting; and (ii) inpatient days resulting from surgical procedures that could have been performed, when medically justified, on an outpatient basis. Payments for these and other unnecessary days cost the Department at least \$10 million in FY85.

In addition, nine of the top ten Medicaid providers of inpatient and outpatient hospital services are major teaching/tertiary care hospitals. Yet, most of the hospital care Medicaid recipients require is routine and need not be delivered in tertiary hospitals which have considerably higher charges than lower cost community hospitals. Indeed, over 90% of all births in Boston occurred in perinatal referral facilities. The specialized services available in the tertiary hospitals raise the operating costs and therefore the charges at these facilities, which accounts for the difference in charges between the tertiary facilities and the lower-cost community hospitals. Delivery of routine care in the more expensive hospitals results in unnecessary spending of at least \$8 million annually.

- o The Department purchases certain durable medical equipment, dental supplies, laboratory and other services from a variety of vendors. While all vendors bill from Rate Setting Commission-established fee schedules, purchasing from many different vendors for a given service prevents the Department from obtaining the economies achievable through volume purchasing and through buying from the most economical vendor of services. This results in unnecessary expenditures of at least \$3 million.

As these examples indicate, inappropriate and unnecessary utilization has a significant cost. The Department has therefore developed and implemented, over the last few years, both short and long-term strategies to solve the program's utilization problems. Following is a brief description of the Department's current utilization control initiatives and a more detailed account of its long-term strategy to alter patterns of care appropriately while ensuring quality.

Short-Term Utilization Control Activities

Based on experience garnered over the first several years of the utilization control program, in FY87 the Department will continue (with refinements) the following short-term initiatives:

- o Institutional Utilization Control

The Department has four initiatives in this area: acute hospital utilization review, chronic hospital utilization review, nursing home prescreening, and nursing home monitoring and utilization review.

- Acute hospital utilization review - federal regulations require that states control unnecessary utilization of acute hospital inpatient services by monitoring the use of such services by Medicaid recipients. Prior to 1982, this

requirement was met by federally-funded Professional Standards Review Organizations (PSROs), which reviewed admissions and lengths of stay of Medicaid recipients in acute hospitals. Subsequent to the termination of the federal program, the Department has contracted directly with PSROs to continue this review function, resulting in greater accountability and closer monitoring of contract compliance. As of November 1985, the Department contracts with one PSRO. This PSRO currently reviews each hospital twice per year, utilizing a sample of cases comprised of at least 10% of all Medicaid discharges from the facility. These samples also include cases involving specific diagnoses or procedures which the Department has identified as indicative of utilization problems.

The Department's utilization review staff perform a similar type of review, including a sample of PSRO-reviewed cases, to monitor PSRO performance. Through PSRO and agency efforts, the Department identified approximately \$1 million in overpayments to acute hospitals during FY83 and FY84 for days of care and services that were not medically necessary.

The PSRO also monitors the quality of medical services provided to recipients. The PSRO contract requires performance of quality assurance studies which can assist the Department in formulating policy concerning coverage of and reimbursement for health care services as well as in identifying areas requiring a more focused review effort.

- Chronic hospital utilization review - professional staff monitor the utilization of services provided to Medicaid recipients in chronic hospitals to determine both whether the patient's medical care needs are being met and whether the recipient actually requires a chronic level of care, as defined by Department regulations. These reviews enable the Department to monitor its policy of paying less than chronic hospital rates for recipients in chronic hospitals who do not require a chronic level of care.
- Nursing home prescreening - a program designed to evaluate all Medicaid recipients seeking a nursing home bed and determining an appropriate level of nursing home or community care. In FY84, of 12,500 cases that were reviewed for nursing home placement, about 8% were diverted to less intensive institutional settings or to the community. Prior experience shows that almost none of the recipients diverted to less intensive levels of care move to a higher level of care during the year following initial review.

In FY85 and FY86 the Department further enhanced the effectiveness of the prescreening program through implementation of the recommendations contained in the 1984 study of the program, performed by an external advisory committee. First, the Department shifted its emphasis from

prescreening hospital patients seeking nursing home beds to reviewing community patients; this is consistent with the findings of the study, which documented a high level of care agreement rate between the Department's staff and the hospitals' discharge planners. Given this relatively high agreement rate, the Department shifted some resources to community cases seeking nursing home placement.

Second, the Department implemented a voluntary program to prescreen private-pay patients seeking admission to nursing homes. This program will act as a safeguard against placing elderly patients in inappropriately intensive settings and will prevent unnecessary spending when payment responsibility is transferred to Medicaid. This approach, recommended by the advisory committee, is a more humane and effective one than screening patients after they enter a nursing home and then seek Medicaid. Making screening available to all those, regardless of payment source, who are seeking nursing home care should also help to ensure that nursing home beds are available for both public and private patients who genuinely need them. In FY85, the Department screened 2,700 private-pay patients. Ten percent received recommendations not to enter nursing homes.

- Nursing home utilization review - professional staff, comprised of nurses and social workers, assist the Department of Public Health in relocating recipients in the event of nursing home closures or other emergencies. Program staff are also responsible for ensuring compliance with federal requirements by following up on deficiencies noted by the Department of Public Health survey staff during their scheduled quality assurance review of each nursing home. Moreover, Department staff seek appropriate placements for recipients whose medical needs have changed to require a lesser level of care than they are currently receiving. During FY84 these activities resulted in the relocation of 57 patients. About 20 individuals were placed in less intensive institutional settings, resulting in more appropriate care for these recipients and in savings for the Department.

o Administrative Control

The Department has five initiatives in this area: volume purchasing of eyeglasses and certain durable medical equipment; encouraging the use of generic drugs; prior approval for certain services and procedures; a pharmacy lock-in for recipients who overutilize drug services; and the Department's acute hospital outpatient department regulations, which include provisions encouraging the shifting of routine care to more appropriate settings as well as introducing prior authorization and record-keeping requirements similar to those with which other providers comply. These initiatives achieve continuing annual savings of approximately \$4 million.

In FY86, the Department will implement additional administrative controls on utilization, including: expanding the list of elective surgical procedures subject to second opinion and prior approval requirements; and requiring that certain dental surgical procedures be performed on an outpatient basis unless medical necessity justifies an inpatient admission.

Long-term Utilization Control Strategy

The initiatives described above address some specific Medicaid utilization problems. Although these efforts represent a constructive approach to solving particular issues, these initiatives are limited in scope and therefore do not comprehensively address the Medicaid program's basic problem: the current fee-for-service reimbursement system, which encourages providers to deliver and recipients to obtain more and costlier services than are necessary, and which offers few incentives for quality or continuity.

With the exception of the Department's nursing home prescreening program, all of the current monitoring activities occur after the service is provided. Retrospective reviews, although they may have some indirect influence on future behavior, are not the most effective method of controlling utilization. Consequently, long-term control of Medicaid costs and assurance of quality depend on a prospective approach which seeks to prevent inappropriate distribution of health care resources, rather than retrospective reviews of treatment patterns. In FY87 the Department will concurrently pursue three long-term strategies to emphasize and promote a more efficient distribution of health care resources. Specifically:

- A. Health Choices for Families and Children - In FY87, the Department proposes to begin implementing a program of Health Choices for Families and Children, in an effort to ensure that Medicaid recipients have the same access to mainstream medical care as more affluent people. All components of Health Choices will include incentives for providers and clients to replace overutilization with efforts to make sure that care provided is necessary and of high quality. This volume's special report on Health Choices, located at the conclusion of the Medical Assistance narrative, describes the proposal and its utilization management incentives in more detail. Since it will take time to implement Health Choices, the Department intends to develop and implement complementary long-term utilization control initiatives designed specifically to ensure a more judicious distribution of resources than under the fee-for-service system.
- B. Acute Hospital Preadmission Screening - The Department is currently considering establishing acute hospital preadmission screening for all elective hospital admissions, excluding obstetric and substance abuse admissions. Consistent with programs implemented by the private sector, the Department would use established and generally accepted medical care criteria. Preadmission screenings of acute hospital admissions would determine medical necessity and appropriateness of the treatment setting.

Implementation of the preadmission screening program would reduce unnecessary admissions and/or shift admissions to more appropriate, less-intensive medical settings. The program will include safeguards to protect recipient access to necessary care.

- C. Review of Provider Practice Patterns - patterned on the small-area comparison analysis (pioneered by researchers at Dartmouth College and Harvard University), the Department will use utilization reports generated through the new management information system and outside databases to highlight atypical practice patterns for comparable diagnoses. The Department will then issue to the relevant professional organizations and key individual providers and institutions a series of analyses both to serve as an educational tool and to indicate appropriate changes in provider practice patterns. It is expected that many providers will alter their patterns of care in response to objective data. The Department will then monitor these providers' subsequent practice patterns to determine whether appropriate utilization changes have occurred. The Department will also concurrently use the findings of the reports as the foundation for revising Medicaid administrative and reimbursement regulations in order to promote more discriminate utilization.

The provider practice analysis project is described in more detail below and on the following pages.

Provider Practice Analysis

The Department intends to make a major effort to capitalize further on the informational features of MMIS, supplemented by other health data sources, in an effort to influence provider practice patterns in the direction of utilization norms. Specifically, patterned on the small-area analysis, the Department will use the Surveillance Utilization Review Subsystem (SURS) and other reports produced by external health utilization review agencies to better understand the dynamics of Medicaid provider practice patterns and Medicaid recipient utilization patterns. These reports, which essentially examine the distribution of diagnoses and treatment protocols on a per capita basis for comparable populations, will be used to highlight atypical practice patterns for identical diagnoses.

Studies show that age-adjusted per capita rates of use of health care services vary significantly. For instance, the Health Planning Council for Greater Boston (HSA IV) in August, 1985 issued a report that showed that wide variations exist in admission rates for certain surgical procedures by hospital in Massachusetts. These variances include: (i) Holyoke residents had their gallbladders removed only one-fourth as often as people in Hingham; and (ii) for fourteen other common surgical procedures, Roxbury residents underwent the fewest surgeries (little more than half the state average) and Holyoke the most (29% above the state average). Moreover, an earlier study found a significant differential in user rates for tonsillectomy procedures for comparable populations in Maine, ranging from a rate of 23 per 10,000 population to 122 per 10,000.

To date, the small-area analyses have examined user rates of selected hospital services for the general population. The results show that variances in treatment patterns are frequent. These variances may be justified, but they may also indicate excessive and inappropriate utilization of services. Provision of inappropriate services, particularly unwarranted surgical care, is both costly and potentially bad medicine as it unnecessarily places individuals at risk of preventable complications and of iatrogenic diseases contracted in the hospital during recuperation.

For example, a recent study of acute hospitals for the Colorado Medicaid program examined various utilization, resource distribution, and quality of care issues by combining physician and hospital claim data to create "disease episode" profiles of Medicaid recipients. This innovative technique permits health care managers to examine all of the costs associated with hospitalization, including ancillary services use, referrals to specialists, and follow up and repeat hospitalizations.

The study revealed several significant issues which will provide the impetus for similar investigation by the Department in FY87. These issues include:

- o Significant variations in payment, ancillary utilization and length of stay per diagnosis among hospitals in the same region. The Colorado study provides the first detailed picture for Medicaid managers of "high cost" versus "low cost" hospitals in the same market area.
- o The problem of potentially unnecessary short stay (one or two days) hospital admissions for a range of surgical and medical services. While much attention has been focused in recent years on diverting uncomplicated surgery to an ambulatory setting, the Colorado study is notable because it found that 39% of medical short stay admissions were potentially unnecessary. These admissions were for diagnoses that are fairly common in the AFDC population, including gastro-intestinal, respiratory and strep throat complaints.
- o Certain quality of care issues at selected hospitals, particularly in the area of maternal complications. The study found that one or two hospitals were significantly higher than their peers in the rate of perineal lacerations, postpartum hemorrhage, and retained placentas. In at least one case, disclosure of the findings led to the replacement of a senior surgeon at a major teaching hospital.

Moreover, other recent national studies indicate that caesarean section deliveries, many of them medically unnecessary, are becoming more prevalent. Preliminary data suggest that the rate of caesarean sections for women on Medicaid in Massachusetts (24%) is higher than the nationwide average of 20%, which is already considered high by some experts. The apparently high rate of caesarean births among women on Medicaid in Massachusetts raises a number of concerns. First, and most important, is the quality-of-care issue. An unnecessary surgical birth

exposes both the mother and the newborn to additional health risks, as well as almost doubling the length of time they spend in the hospital. Second is the issue of cost. The Department pays for a caesarean section roughly twice what it pays for an ordinary delivery. In addition to the surgical fee, post-operative care is likely to be more intensive and recovery time longer, increasing the cost associated with each caesarean section. In summary, given that about 100,000 women of child-bearing age are eligible for Medicaid, the issue of medically unjustified and costly caesarean section deliveries is of particular importance to the Department.

Another problem is the rapid dissemination and implementation of medical procedures with unproven or questionable efficacy. Nationwide, over the period 1970 to 1983, the number of coronary-bypass operations increased from 13,000 to 191,000. In a recent journal article, a prominent cardiologist noted that "fully half of the coronary-bypass operations performed in the United States are unnecessary." Although this is undoubtedly a dramatic example, it does illustrate the fundamental point: inappropriate utilization of medical care is prevalent and consumes scarce resources that could be deployed for more critical needs, both for the general population and for the Medicaid population.

In response to these studies and in an effort to control costs and improve quality, nationwide and in Massachusetts, a coalition comprised of representatives of business, public and private payors has formed to address this issue. These groups are independently and collectively restructuring their benefit plans and utilization control programs to ensure quality through less invasive medical care. One approach is to foster substitution of less expensive medically appropriate services for higher intensity services. Such a measure primarily seeks to shift delivery of care from an institutional setting to an ambulatory care facility. One example is the reimbursement of certain surgical procedures in ambulatory surgical centers. Blue Cross of Massachusetts, which insures about 60% of the population in Massachusetts, has been a chief proponent of this approach and has altered its benefit plans accordingly.

Although the provider community might view these activities by private and public institutions as an unwarranted usurpation of its professional authority, basic economic realities suggest that third-party payors are likely, over the next few years, to develop even more aggressive initiatives to control utilization, rather than remain idle in the face of ballooning expenditures for health care. Moreover, these efforts are likely to receive the continued support of the business community, which continues to be alarmed over the proportion of revenues absorbed by health benefits.

As indicated earlier, the seminal information on small-area analysis of medical treatment patterns is specific to the general population, not to a low-income/Medicaid population. Moreover, the studies have examined primarily hospital user rate variables, such as number of admissions per 1,000 population. Similar user rate variances among services are likely to exist within the Medicaid population, as well as between the Medicaid and non-Medicaid populations. In addition, this phenomenon of uneven

user rates is likely to extend to services other than hospital care. In FY87 the advanced capabilities of the new Medicaid Management Information System (MMIS) will allow the Department, for the first time, to direct attention to unusual patterns of activity that would otherwise be undetectable. Through information generated by several sources, the Department intends:

- o to use provider-specific mailings and meetings to explain to providers how their practice patterns differ from anticipated patterns. Providers will have an opportunity to explain why they are furnishing larger amounts of services than their peers.
- o to establish corrective action plans with providers and provider associations where there is clear evidence of unusual patterns.
- o to use clinical audits and increases in the number of procedures needing prior approval in order to correct continuing patterns of excessive service delivery.
- o to reward providers offering high-quality care which responds to client conditions rather than being either substantially more or substantially less than clients need.

Provider Practice Patterns Reports

Following is a synopsis of the prospective analyses which will be shared with the provider community in an effort to alter treatment patterns in line with norms, and will be used by the Department to support changes in program operations.

o Acute Hospital

The Department will spend about \$385 million for Medicaid acute hospital inpatient and outpatient services in FY86, or nearly one third of the Medicaid budget. Although there is a wide range of charges among hospitals, the average Medicaid hospital charge per day is \$350. If the Department could eliminate 5% of the total unjustified days of care, a total of \$10 million would be saved. Moreover, savings could also result from a more judicious use of ancillary resources, both pre-operative and post-surgery; improved efficiency through substitution of less intensive treatment protocols (e.g., ambulatory care surgery); and shifting of routine care from acute to community hospitals. The Department intends to conduct the following acute hospital analyses:

- Appropriateness of Admissions - During the second half of FY86 the Department will contract with the Health Data Institute (HDI) to conduct a major review of the appropriateness of admissions at twelve acute care hospitals that account for more than 50% of Medicaid inpatient expenditures, or approximately \$120 million. HDI will use the Appropriateness Evaluation Protocol (AEP), an instrument that permits a nurse reviewer to assess clinical criteria in

hospital discharge records and determine the medical necessity of an admission or subsequent days of care.

The AEP technique will be applied to a random sample of medical records at the twelve hospitals under review. HDI will then tabulate the results and estimate the percentage of medically unnecessary admissions and days of care for the Medicaid population at these hospitals. The AEP, developed with financial support of the federal government, has been tested for reliability in all sections of the country and within various types of hospitals. One nationwide study using the AEP found rates of inappropriate admissions ranging from 12% to 28% depending upon the geographic region. Although acute hospital admission rates have dropped steadily since this study was performed (with a likely decrease in the number of inappropriate admissions), recent reviews using the AEP indicate that the rate of inappropriate admissions may still be in the 10% to 15% range.

One of the advantages of the AEP technique is that the criteria-based instrument identifies reasons for inappropriate admissions. While some factors may not be fully within the control of the hospital (e.g. an elderly patient awaiting a nursing home bed), other reasons for inappropriate hospital stays can be traced to practice patterns of particular physicians. Thus, a hospital can use the AEP results to provide feedback to its own staff about avoidable causes of unnecessary admissions.

- Average length of stay per selected diagnosis - this basic report will show variances by hospital in lengths of stays for the most frequently used Medicaid services.
- Ancillary use per selected diagnosis - this report will compare usage of laboratory and radiology examinations per diagnosis among hospitals. Although there may be valid reasons for certain hospitals' averages to lie outside the statistical norm, these results may also indicate that a majority of the physician staff is routinely ordering too many tests.
- Frequency distribution report on emergency room services - Many Medicaid patients rely on hospital emergency rooms for routine care that they could obtain less expensively in a community health center or a doctor's office. Examples of the many conditions inappropriately treated in the emergency room include ear and upper respiratory infections. National data show that visits to hospital outpatient departments and emergency rooms account for 21% of Medicaid recipients' visits to medical providers, while outpatient department/emergency room visits account for only 12% of visits by the general population and 11% of visits by the privately insured. The Department will produce a report showing the distribution of Medicaid emergency room visits by diagnosis by hospital.

Alone, this report will not indicate whether treatment was appropriate or necessary. However, the results will enable the Department to concentrate follow-up analyses on those hospitals that provide the bulk of emergency room care to determine whether the services were justified. Acute hospital inpatient days per emergency room visit are one potential proxy to measure the appropriateness of emergency room care. Presumably, "true" emergencies on average would require some follow-up acute hospital inpatient care. On the other hand, hospitals that provide routine care in emergency rooms would not appropriately admit a high percentage of these patients into the inpatient facility.

An exact cost estimate of unnecessary emergency room spending is not available. However, Medicaid spending for hospital outpatient services (which includes emergency room services) was about \$111 million in FY85. If 25% of this spending was for emergency room care, and 20% of that was for care that recipients could obtain elsewhere at half the price, the Department could save about \$3 million by shifting inappropriate care out of the emergency room. In addition to the high cost, frequent use of emergency rooms is an indicator of potentially poor quality. Recipients do not necessarily receive comprehensive, continuing care, nor do they usually have access to their own personal physicians. As such, it is particularly important that the Department identify those individuals who rely on hospital outpatient departments/emergency rooms for their primary care, and encourage those individuals to enroll in coordinated health plans. This would result in improved care for the individual and savings for the state.

- Frequency distribution report on number of procedures performed on an inpatient basis that could be performed in an ambulatory care center - Brigham and Women's Hospital has identified a list of 60 elective procedures that must be performed on an outpatient basis only, except if a waiver is obtained from an internal utilization review board. Among these procedures are biopsies for certain lesions, bronchoscopies, and tooth extractions. A Department analysis of the 1983 Rate Setting Commission acute hospital case-mix data indicated that approximately 32% of surgical discharges were for diagnoses that could have been handled on an ambulatory basis. A report focusing on how individual hospitals handle this issue will highlight those hospitals that rely excessively on more resource-intensive inpatient care for these elective procedures. Consistent with the Brigham and Women's example, the Department will develop a list of elective admissions that must ordinarily be performed in an ambulatory care setting.

- Exception report for pre-operative days for certain elective procedures - the purpose of this report is twofold: first, to analyze the setting used to provide pre-operative services for elective procedures (in some instances, pre-operative ancillary services can be provided in an ambulatory care center, thus avoiding inpatient room and board charges); and second, if the pre-operative services were provided in an inpatient facility, to determine whether these services were performed on the same day as the surgery. In many instances, careful scheduling can avoid unnecessary pre-operative days in the hospital. A Department analysis of the 1983 Rate Setting Commission acute hospital case-mix data indicated that approximately 21% of the surgical discharges (or about 3,000 cases) had two or more pre-operative days of care.

The Department will provide incentives to promote utilization of ambulatory care settings for pre-operative ancillary tests for certain elective procedures (savings estimated at \$250 per procedure) and/or to encourage some pre-operative ancillary tests to be performed on the same day as some elective surgical procedures (thus eliminating one day of costs).

- Frequency distribution of routine diagnoses by tertiary hospital - a Department study in 1983 documented that Medicaid often pays for the site where the health care is delivered rather than for the medical service itself. The study showed that in certain cases, the OPD charge was 500% more than for the same service provided in a community health center. (Among the procedures reviewed were well-child examinations, ear examinations and gynecological histories and examinations.) The study compared ambulatory services provided by hospital OPDs and freestanding community health centers. The same relationship exists among inpatient facilities, as there are significant charge differentials for the same services provided in tertiary hospitals and general community hospitals. Reports that the Department is currently developing would indicate the amount of savings that could be generated through implementation of policies that redirect individuals from high-cost tertiary hospitals to lower-cost community hospitals for routine procedures.

o Nursing Home

The Department spends about half of its Medicaid budget on services provided to the more than 35,000 Medicaid nursing home recipients. Of this amount, about \$450 million (FY85) represents room and board and nursing services, which are covered through the daily per diem. In addition, based on an earlier Department study of ancillary service usage by nursing home recipients, an estimated amount of over \$100 million is spent for care not covered through the per diem (such as hospital care, physician care, laboratory, radiology, and drugs).

The Department's prescreening program ensures that Medicaid individuals are placed at the appropriate level of nursing home care. However, the quality of care provided to Medicaid nursing home recipients varies. Recent Department utilization review data confirm the commonly assumed view that there is an uneven use of ancillary services by residents in nursing homes. For instance, some nursing homes routinely schedule monthly vision care and podiatry visits for all of their residents, regardless of need. On the other end of the spectrum, the apparent reluctance of the physician community to provide comprehensive primary care services for nursing home recipients results in inappropriate utilization of hospital emergency rooms. Delayed treatment also sometimes results in failure to notice problems at a stage where basic treatment could prevent serious illness.

The Department will analyze the utilization of ancillary services, including drugs, by level of care for individual nursing homes. Nursing homes with ancillary user rate averages outside the statistical norm will be encouraged to participate in the Department's nurse practitioner program. Experience with the program suggests that, through the provision of timely, continuing primary care, significant savings to Medicare and Medicaid result from reductions in utilization of hospital emergency rooms, reductions in number of hospital admissions, and reduction of lengths of hospital stays.

o Physician

As the gatekeepers to medical care, physicians make most health care utilization decisions. Physicians evaluate the patient, diagnose illness, provide treatment, refer patients to specialists, admit individuals to acute hospitals, prescribe treatment protocols, and monitor patient compliance.

The Department spent about \$56 million in FY85 for services directly provided by physicians. The Department intends to examine the following physician-related issues:

- frequency of laboratory tests and radiology tests per office visit by diagnosis;
- frequency distribution of surgical procedures by physician specialty;
- frequency of surgical follow-up care for the top 20 procedures for Medicaid clients; and
- frequency distribution of referrals made to specialists.

o Pharmacy

The Department spent about \$64 million for Medicaid pharmacy services in FY85. Utilization analyses will concentrate on the following area:

- Prescription psychotropic drugs - the purpose of this report is to determine whether psychotropic drugs are being prescribed excessively. Based on the analysis, certain recipients could be enrolled in the pharmacy lock-in program.

CARING FOR THE ELDERLY

INTRODUCTION

One of the most serious problems confronting the Commonwealth in general and the Medicaid program in particular is how to provide affordable, quality care to a growing elderly population. The Department's goal, consistent with overall state policy, is to ensure that elderly individuals are treated at all times with dignity and have the maximum opportunity to live in the least restrictive possible setting consistent with their social and medical needs. The Commonwealth, primarily through the Departments of Public Welfare and Elder Affairs, currently provides a wide range of medical, social, and housing services for the elderly. Despite these efforts, there are certain structural problems with the current long-term care delivery system which thwart achievement of this basic goal, including:

- o inadequate coordination among various service systems - fragmentation and lack of coordination in policy making and implementation of new programs cause maldistribution and inequitable allocation of scarce resources, duplication of programs, and gaps in coverage.
- o service utilization is a function of reimbursement, not need - with the exception of Medicaid, the existing financing sources for long-term care services do not provide adequate coverage of the range of community health services. This situation, coupled with the relatively easy availability of Medicaid coverage for institutional care, often results in unnecessary and premature nursing home placement of elders, which can have a deleterious effect on the quality of life.
- o maldistribution of Medicaid resources - in FY85, the Department spent \$579 million, or about 50% of the Medicaid budget on nursing home and chronic hospital care. In stark contrast \$48 million, or only 4% of the Medicaid budget, was spent on community-based long-term care services. Continued overreliance on costly institutional long-term care eventually could imperil the state's ability to fund other equally vital public assistance programs.
- o long-term care is prohibitively expensive, potentially impoverishing middle-income elders - chronic illness can financially and emotionally devastate an elderly individual or family. Given the lack of comprehensive private long-term care health insurance coupled with the high cost of care, the need for ongoing health and social services for the chronically ill can impoverish even middle-income individuals, forcing them to rely on public assistance.

The current situation confronting the elderly -- increased longevity with resultant different and increased service needs -- makes the existing long-term care system less and less acceptable given the state's

commitment to ensuring compassionate, comprehensive, and cost-effective care for the elderly. Accordingly, in this report on caring for the elderly in Massachusetts, the Department will further outline the dimensions of the problem and propose specific initiatives intended to address these inequities. In brief, the Department believes that the establishment of a more effective, comprehensive long-term care system, one which would allow individuals the maximum opportunity to remain in the community, requires critical attention to the following components:

- o improved coordination both between and among providers;
- o expansion of noninstitutional alternatives to fill gaps in the current system;
- o expanded development of residential alternatives for elders (including exploring the possibility of developing a continuing care retirement community for low-income individuals);
- o financing, especially maximization of third party resources;
- o better utilization of nursing home resources.

The ultimate goal of developing a long-term care system along these guidelines is consistent with the precepts upon which the Department's Employment and Training (ET) and proposed Health Choices programs are built: providing elderly individuals with options among appropriate services in settings that maximize these clients' opportunities for both economic and functional self-sufficiency. As will be detailed, the achievement of this goal through this proposed system will require the integration of currently existing services with new approaches to long-term care.

BACKGROUND: THE ELDERLY TODAY

To put the problems associated with caring for the elderly in proper perspective, it is necessary to briefly identify some important aspects of the situation facing today's elderly population, while noting how these issues differ from those experienced by their predecessors.

First, due to advances in medical technology and to a declining birth rate, there has been a significant increase in both the absolute number and the proportion of the total population that is elderly, a trend which will intensify over the next 50 years. Specifically:

- o There has been a near tripling of the percentage of Americans over 65 years of age since the turn of the century;
- o The oldest segment of the elderly population nationwide has grown at an even greater rate -- the aggregate number of people between the ages of 75 and 84 has increased by a factor of eleven while the over-84 population has risen to twenty times its turn of the century level;

- o The chart on the following page shows that about 13.2% of the state's population is 65 years of age or over, compared with 11.4% of the population nationally in 1983. In essence, Massachusetts has aged even faster than the rest of the nation; and
- o Most notably, these growth trends are expected to continue. After a slight lull in 1990, it is projected that by 2020 the elderly as a proportion of the population should be approaching approximately twice its current level -- a full 1.1 million people over 65 in Massachusetts alone. A commensurate increase in the state's supply of nursing home beds in response to this growth would cost the Medicaid program an estimated \$200 million more per year in current dollars. It is not clear where resources of this magnitude would come from; they may be necessary if the state does not solve the problems in the existing long-term care system.

Moreover, today's elderly population largely has a different and greater set of health care and social service needs than does its predecessors. Medical advances have eliminated or controlled most of the acute illnesses which were the prime causes of morbidity among the aged earlier in the century. With increased longevity has come an increasing occurrence of chronic illnesses and accompanying functional limitations. Specifically:

- o The National Center for Health Statistics found that 81% of those over 65 years of age have at least one chronic condition, and that over 45% of these people suffer related activity limitations.
- o Some of the most frequent of these ailments are arthritis, hypertension, Alzheimer's Disease, hearing impairments, and heart conditions.
- o As chronic illnesses are characterized by gradual onset and progressive degeneration, these conditions tend to worsen with age.
- o These chronic ailments require attention not only to medical problems, but also to social and emotional needs.

But the problem is not simply chronic illness and an increase in the number of elderly. Traditionally, families and friends have provided 75% to 80% of the care which the chronically ill and disabled elderly receive. However, while the number of frail elderly grows, the capacity of these traditional networks diminishes. Nationally, 20% of those over 65 years of age have no surviving relatives. In 1980, 25.5% of Massachusetts' elderly lived alone. Moreover, those who do have surviving relatives often find that these care-givers, too, are aging and nearing retirement. The increased participation of women in the work force and the general aging of the population are key factors in this trend.

These demographic factors have contributed to the need for the state's Medicaid program to cover a larger than average proportion of the state's population. While nationally, 5.5% of the elderly are SSI eligible, Massachusetts' SSI program includes 6.9% of the state's elderly. In 1983, national Medicaid spending on the elderly averaged \$418 per person (recipients and non-recipients) aged 65 or more. Massachusetts Medicaid spent \$844 per elderly individual. The following table provides a comparison of the Commonwealth and nationwide demographic data for the elderly.

COMPARISON BETWEEN THE COMMONWEALTH AND NATIONWIDE DEMOGRAPHIC
DATA FOR THE ELDERLY

<u>INDICATOR</u>	<u>MASSACHUSETTS</u>	<u>NATIONWIDE</u>
% of population 65+	13.2%	11.4%
% of elderly population 75+	43.2%	42%
% of elderly living alone	25.5%	20.0%
% of elderly SSI-eligible	6.9%	5.5%
% of elderly population covered by Medicaid	12.0%	11.5%
% of elderly population below the poverty line	8.7%	14.2%
Medicaid spending per elderly person	\$844	\$418
Nursing home beds per 1,000 elderly (1980)	72.2	57.5
% of elderly in nursing homes or chronic hospitals	7.1%	4.8%

PROBLEMS WITH EXISTING LONG-TERM CARE DELIVERY SYSTEM

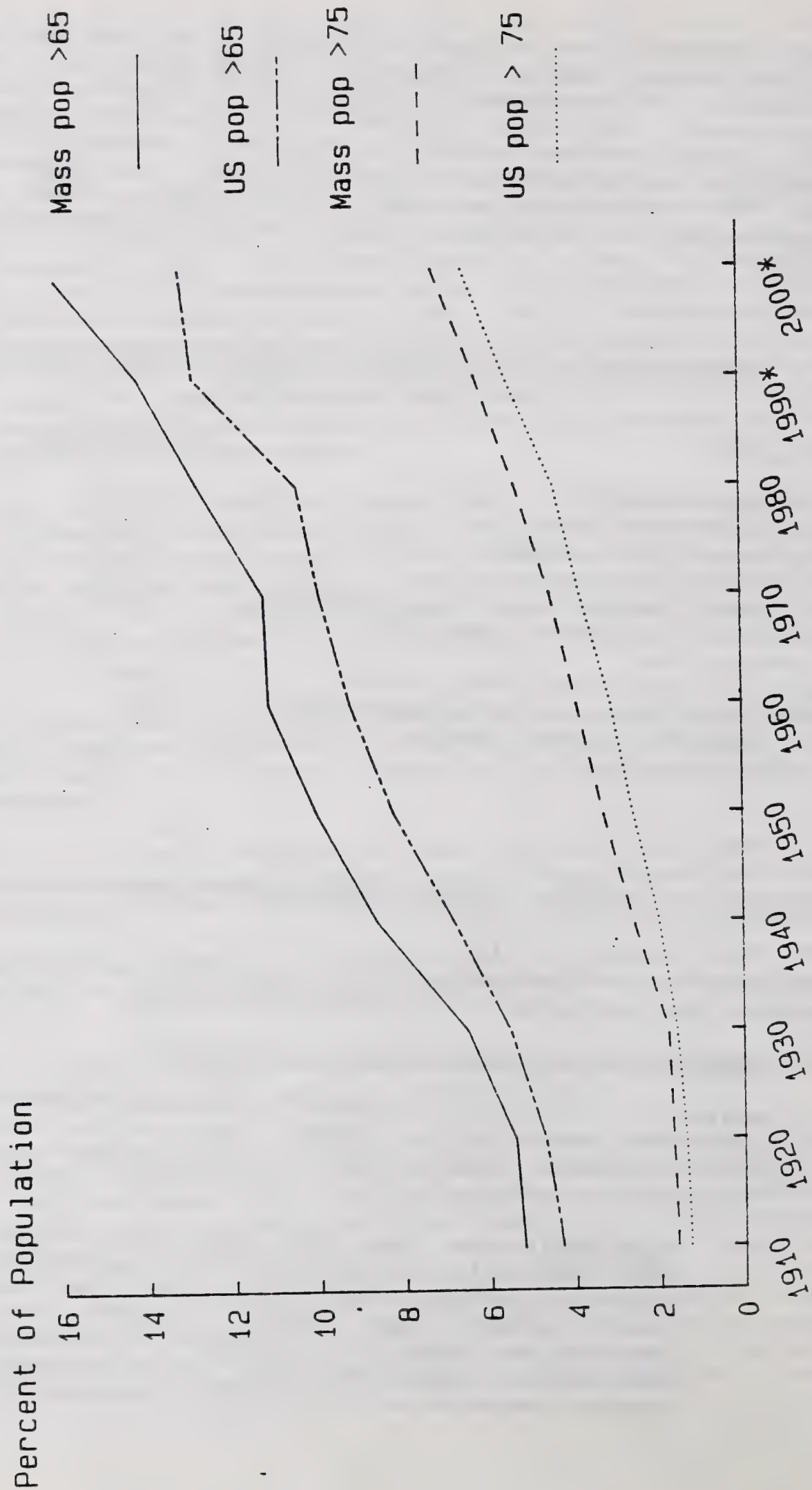
Providers and policymakers generally concur that the existing long-term care delivery system has the following deficiencies:

A. Fragmentation and Non-coordination of Services

Despite the good-faith efforts of policymakers and providers, the specialized design of the current long-term care system neither promotes service coordination nor an efficient distribution of resources. For example:

- o government - no fewer than eight public agencies play a significant role in providing or ensuring quality of services delivered to the elderly population: the Departments of Public Welfare, Elder Affairs, Public Health, and Mental Health, the Executive Offices of Transportation and Construction, and Communities and Development, the Rate Setting Commission, and the Attorney General's Office.

CHARACTERISTICS OF THE ELDERLY POPULATION: MASSACHUSETTS AND NATIONWIDE



* - projected

- o private - a multitude of provider agencies render care to the elderly, including: acute hospitals, nursing homes, rest homes, chronic hospitals, home health agencies, community health centers, home care corporations, and physicians.

Theoretically, the intent of a system designed to address specific needs is commendable. However, in practice, the system is too piecemeal and inflexible, frustrating the integration among and within public and private agencies that is necessary for true responsiveness to client need. The consequence is that many elders' needs are not met in a timely manner, and/or that these needs remain unmet until the onset of acute illness. As a result, this health care safety net can become entangling rather than support providing.

For example, consider the case of a 76-year-old widow living alone in subsidized elderly housing. She has many close friends but her family does not live nearby. Her arthritic condition leaves her unable to perform routine housekeeping tasks. She also struggles with many activities associated with personal grooming. In addition, she requires assistance with managing her finances. Her neighbor employs a private homemaker service to assist with household chores. She obtains the name of the agency from her neighbor and arranges to "purchase" help to assist her with those tasks which she is totally incapable of performing, such as heavy cleaning. Because of her ad hoc method of entry into the current multifaceted long-term care system, she is unaware that she may qualify for assistance through the state-funded Home Care Corporation program. She also continues to struggle with her personal activities of daily living. Her home health needs remain unidentified until she falls getting out of the tub and is hospitalized. She then may spend longer than necessary in the hospital if no one assists her in funding the services she needs to return home -- and may, in fact, end up in a nursing home.

As an elder grows more frail and less self-sufficient, the need becomes greater for an integration of social and medical support services. Unfortunately, few elders are aware of the array of noninstitutional services available to address their needs. Moreover, arranging for one's own care from a dizzying array of social and medical providers can be extremely taxing to an older person, particularly one who has recently experienced a serious illness and has no family support. All too often, the elder will seek nursing home placement because, by default, it is the most accessible option. In essence, this crisis-oriented, poorly coordinated approach to delivering long-term care services further exacerbates the existing bias toward institutional care.

B. Service Delivery Based on Reimbursement, Not Need: Bias Towards Institutionalization

Government and private insurers have established a long-term care reimbursement system biased towards the provision of institutional care. First, despite recent significant increases in the aggregate number of programs and funds devoted to community care alternatives, the Commonwealth still spends a disproportionate amount for nursing home and chronic hospital care: an estimated ratio of 12 (\$579 million) to 1 (\$48 million) in FY85.

Second, even more important than relatively modest spending on community services is the unavailability of alternative health care financing. Medicare and other third-party payers only minimally cover long-term care services, including nursing homes and noninstitutional services. This gap in insurance coverage for the non-poor discourages many elderly from using needed community health services, services which, though considerably less costly than nursing home care, can seem exorbitant to an elderly person on a limited income who must pay totally out of pocket. However, an underutilization of preventive- and maintenance-type care may hasten the decline of good health and independence, and hence cause an increase in the need for nursing home care -- the cost of which will almost certainly be eventually borne by the Medicaid program.

The present system of financing long-term care creates undesired incentives: to use institutional care inappropriately because it is more financially accessible via Medicaid; or conversely, to become impoverished so as to gain financial assistance for needed health care in the community. Elders in the latter situation transfer or spend excess cash and liquid assets in order to qualify for Medicaid. Currently, it is significantly easier to achieve Medicaid eligibility via this route in an institutional setting than it is in the community. Individuals in nursing homes may become eligible for Medicaid if the cost of their care in a given month plus a \$55 allowance for personal needs exceeds their net monthly countable income. Given the average monthly cost of skilled nursing home care (\$1700) and that other medical expenses for recipients average about \$300 per month, one can safely assert that most nursing home residents (over 70%) are on Medicaid because few have sufficient income to pay for their care. On the other hand, spenddown in the community is calculated on a six-month basis. Medical expenses equal to six times the difference between one's net countable monthly income and the Medicaid community income standard of \$451 must be incurred some time during a six-month period, at which point the individual is Medicaid-eligible for the remaining months. The problem is that it is extremely difficult for many of these individuals to both incur medical expenses sufficient to meet this requirement and maintain funds for food, shelter and family support. Moreover, this bias towards institutionalization and away from community-based care is of concern for the following additional reasons:

- o Quality - nursing home service is one of the most restrictive forms of care. Further, this restrictiveness has been proven to be unhealthy to those who are not appropriately placed, as reflected in contentment/satisfaction indexes, and functional ability measures.
- o Appropriateness - more than 10% of those in nursing homes do not require nursing home care. These inappropriate placements result both when recipients' conditions stabilize or improve after entering homes, and when placements were inappropriate in the first place.
- o Access - a costly by-product of inappropriate placement is the unavailability of nursing home beds for individuals truly requiring this level of medical care. When a nursing home bed is not available for a Medicaid patient whose admission to a nursing home has been approved by the Department's nursing home prescreening unit, the Department authorizes care in an acute hospital until a placement can be secured. These are known as "Administrative Days" or "ADs", and are estimated to cost the state upwards of \$150 per day. The AD situation is serious. From 1980 through 1984, an annual average of almost 700 individuals spent a total of 35,000 days on AD status, at a projected total cost of more than \$25 million. Further, Department reports (quarterly snapshots) indicate that more than 10% of the AD patients are on AD status for over 90 days.

C. Maldistribution of Medicaid Resources

Overdependence on institutional long-term care results in a maldistribution of Medicaid program resources. Even after deducting the recipient's contribution to the cost of nursing home care (on average, roughly \$4,800 per year), it can cost the state between \$13,000 (intermediate nursing care) and \$19,000 (skilled nursing care) per person per year in a nursing home. Chronic hospital care is even more expensive than nursing home care. Total Medicaid nursing home and chronic hospital costs in FY85 were \$579 million, or about 50% of the Medicaid budget. In contrast, less than 5% of the Medicaid budget was spent on community based long-term care.

This bias towards institutionalization is reflected in the distribution of Medicaid expenditures. From FY80 to FY84, over one-quarter of the total Medicaid budget (which in FY85 exceeded \$1.2 billion) was spent on nursing home services for just over six percent of the total Medicaid population -- and this does not include other health care costs incurred by these people outside the institution.

Further, based on Department of Public Health projections of potential bed need, it is estimated that Medicaid will pay an additional \$52 million by 1990 to fund operating costs associated with construction of new nursing homes. In an era of limited state and declining federal financial support for Medicaid, these facts underscore the need for the state to find less costly ways of caring for the elderly.

D. The Unmanageable Expense of Long-Term Care: Impoverishment of the Middle-Income Members

Most people over 65 in this country are living relatively comfortably, well above the poverty line. However, given the potential impact of high out-of-pocket payments for health care, particularly for long-term care, any significant decline in an elderly individual's health status could be immediately devastating -- even to the best situated of the middle class. A recent report prepared by the U.S. Congress's Select Committee on Aging documents clearly the projected magnitude of the problem:

- o Between 1984 and 1990, the elderly's health care payments are expected to rise twice as fast as will their income.
- o Per capita payments by the elderly for health care are expected to triple between 1977 and 1990, from \$712 annually to an estimated \$2,583 annually.
- o The elderly's out-of-pocket health care costs in 1985 are projected at about \$1,660 per person -- an average annual increase of 11.4% since 1980.

Perhaps the most alarming aspect of health care costs is the suddenness with which it can devastate an elderly person upon the onset of a crisis. Consider the impact of Alzheimer's Disease. Currently, it affects 5% to 7% of the people 60 to 79 years of age, and 20% to 30% of those 80 years of age or older. The antecedent risk factors associated with the disease have been difficult to detect, thus an elder can be "blind-sided" by both its physiological and its financial impact. The cost to maintain an Alzheimer's victim is \$22,000 annually in a nursing home and \$13,000 per year for home care.

The results of studies performed in Massachusetts for the Congress show just how quickly an elderly person and that person's spouse could be impoverished by this disease. Specifically, the reports indicate that over 60% of elderly persons aged 66 and older impoverish themselves after only 13 weeks in a nursing home. Especially important to note is the fact that, should such a crisis strike one member of an elderly couple, both of them may become impoverished and both of their future health care needs may have to be funded by Medicaid. Thus, in short, if you are elderly and you develop a serious illness, the chances are great that you will also become destitute. The unintended outcome is the extension of Medicaid coverage to middle-income people.

PROPOSED SOLUTION

The state and all other interested parties need to work together to revise the long-term care system to better ensure that the elderly receive care in the least restrictive and most dignified manner possible. A primary goal is to make alternative services as financially and programmatically accessible as is institutional care. People do not work their entire lives to retire into an existence of austerity, self-deprivation, and confinement.

As the Department's existing ET Choices and proposed Health Choices programs do for their clients, pursuit of the following plan should also create a system which similarly maximizes opportunity and personal independence for the Department's elderly clients. This remodeled and better arranged system should also be more cost-effective.

Accordingly, the Department is proposing a 5-pronged strategy to achieve the goal of ensuring quality of care for the elderly population. Specifically:

- o Improved integration and coordination of support services;
- o Improved management and targeted expansion of noninstitutional programs;
- o Development of new and expanded residential programs;
- o Development of a broader financing mechanism for long-term care services; and
- o Better management and utilization of nursing home resources.

It is also important to note here that the state is not without resources in this venture. A substantial programmatic base presently exists. The Department itself currently provides care to approximately 54,000 elders with its long-term care programs: about 40,000 in institutional long-term care facilities (nursing homes and chronic disease and rehabilitation hospitals) and about 14,000 through community care programs. The Department's goal for FY87 and beyond is to manage these programs and the long-term care system to benefit clients, make better use of scarce resources, and prepare for continuing growth in the elderly population.

A. Integration of Services

Current efforts by state and private agencies to improve the quality and cost-effectiveness of services for the elderly are valuable. However, the complexity of this issue -- parting agencies and providers accountable for the cost-effectiveness and utility of services they are offering. Aspects of such management should include:

- o early intervention - elders should be informed of the availability and mix of long-term care services and options prior to a serious health care problem;
- o case management - upon entering the long-term care system, each elderly client should receive a comprehensive evaluation of his/her health, social, and financial needs. Aing agencies and providers accountable for the cost-effectiveness and utility of services they are offering. Aspects of such management should include:
 - o early intervention - elders should be informed of the availability and mix of long-term care services and options prior to a serious health care problem;
 - o case management - upon entering the long-term care system, each elderly client should receive a comprehensive evaluation of his/her health, social, and financial needs. A primary care manager should be responsible for the care planning and case management, which should be based on this evaluation;

- o continuity - ensuring services and follow-up beyond the initial assessment.

In short, such a coordinated long-term care system should work such that regardless of where an elder individual enters it, each person will encounter a similarly broad selection of care options, which will be managed efficiently by the primary care management agency.

An important element of such an integration of services may be the introduction of a universal assessment instrument acceptable to all service providers -- state agencies, home care corporations, visiting nurse associations, and other community-based providers, and nursing homes. The primary advantages of a common assessment tool are that it would facilitate the development and implementation of a coordinated care plan, helping to ensure continuity in the multiple-entry point long-term care system. Further, a common assessment tool would allow long-term care providers to better evaluate the utility of a given program, an important point given the fact that resources will need to be spread over a larger demographic base in the future.

Actual program experience suggests that a coordinated approach is effective, both in terms of quality and cost. For example, the goal of the Lynn Channeling Project was to rationalize the delivery of long-term care to severely impaired elders by managing clients' service utilization. The innovative approach taken to achieve this goal was making the case manager both the arranger of services and the dispenser of funds. The cost of each elder's services could not exceed a cost cap of 60% of the average skilled nursing home rate; it was the responsibility of the case manager to determine the amount, scope, and duration of care while devising a care plan within this budgetary limit.

A case management program currently operated by the state (the Community Care Connection) also features many of the components being discussed here as essential to achieving service integration. A joint venture between the Welfare Department and the Department of Elder Affairs, this program is designed to provide home health and social services to elderly individuals who might otherwise seek placement in a nursing home. Through this program, a single provider -- the "lead agency" -- coordinates the delivery of these services for enrollees living within a given geographical service area. Nine lead agencies have been selected, including seven home care corporations, one VNA, and one hospital-based program.

Client assessment and care plans are prepared jointly by a home care case manager and a home health agency nurse upon enrollment. Quarterly reassessments and care plans are required. Prior to participation, all prospective enrollees are screened by a Welfare Department nursing home prescreening team. Only those approved for level II or III nursing home placement are eligible to participate.

Under an interagency agreement, Welfare and Elder Affairs are cooperating to provide funds for the program and to jointly sign

contracts with lead agencies. Paid in the form of a daily capitation, the lead agency has primary control over allocation of these funds. Should the agency be able to provide the necessary services for less than what the state pays it, it keeps a portion of the savings.

Currently, 250 frail elders are being served in this new program. About 50 of these enrollees were participants in the Lynn Channeling project. By the end of this new program's first year of operations, an increase to 1,000 enrollees should occur, with continued expansion through FY87.

B. Expansion of Noninstitutional Alternatives

Another, equally important focal point of an improved long-term care system is the availability of a full complement of alternatives to care in nursing homes and chronic hospitals. It is both possible and desirable to maintain more low-income elderly in the community.

Currently, the state operates three programs which begin to meet the daily health and social services needs that will allow elders to remain in a community setting. The extent to which these programs (detailed below) have been effective correlates with the extent to which they have been coordinated with case management efforts such as the Community Care Connection and Channeling. In effect, these programs could serve as models for the case management system. Specifically:

- o The Department serves about 13,000 elders per month with noninstitutional long-term care services. These include home health services, adult day health services, and adult foster care services. Worthy of particular note is the inclusion of a special adult day health program for Alzheimer's victims. Consistent with the recommendations of the Governor's Committee on Alzheimer's Disease, this program includes: programs of mental stimulation to help maintain the cognitive capacities of patients, counseling and therapeutic services, and improved staff/patient ratios -- all of which are important in care at the advanced stages of this disease. In FY86, the Department will offer services at a second site, and is considering development of two other sites for FY87.
- o In FY85, the Department of Public Welfare began implementing, with the Department of Elder Affairs (DEA), a federally-approved home- and community-based services waiver that provides Medicaid reimbursement for home care services for Medicaid recipients. Offered through DEA's home care program, these services were previously funded at 100% state cost. At the end of FY85, respite care services -- one service especially necessary to enable frail elders to remain in the community -- became a part of this service package. 1,100 frail elderly Medicaid recipients are expected to participate in this program in FY86. The period for operation of services under this waiver ends in December, 1986. Should the state be

successful in gaining an extension to continue operations, an additional 2,200 recipients will participate in FY87, bringing the total to 3,300.

- o Under a second federally-approved home- and community-based waiver, the Department has been providing personal emergency response system (PERS) services to a select group of elderly and disabled individuals at risk of institutionalization since FY85. PERS is a communications apparatus providing geographically and socially isolated individuals 24-hour direct access to a medical control center. Through an electronic device, the individual is able to alert the control center whenever a medical problem arises. In FY85, two areas of the state were served by three providers, which enabled up to 200 people to be served. The Department has applied for permission to offer services in five additional areas in FY86, so that 375 more individuals can be served (a total of 575 persons for the seven areas). For FY87, the Department plans to seek federal authorization to offer PERS statewide, expanding the potential user-population to 1000.

C. Housing

Though much medical and formal social support is available to individuals at risk of institutionalization, there is an apparent shortage of supportive residential alternatives. This often contributes to inappropriate nursing home utilization. Even those who own their own homes may be faced with physical and/or financial barriers to remaining at home. Thus a significant component of any improved case management system should be an assessment of both the elders' current housing situation and future housing needs. The development of a coordinated long-term care system should include the development of a full range of alternative community living situations, including:

- o Adult Foster Care - As noted, the Department provides Adult Foster Care (AFC) services to Medicaid recipients through its own efforts and in conjunction with DEA. AFC is a service which places frail elderly persons, who do not have the necessary social supports, with unrelated families who care for them in return for a small stipend. 185 frail elders (158 of whom are Medicaid recipients) have been placed in such settings through FY86. As this program provides high-quality care in a cost-effective manner (\$8508 per year in a "host home" vs. \$14,000 to \$19,000 for nursing home care), the Department will examine a number of approaches to boost enrollment.
- o Life care communities - In FY86, the Department began to explore ways of making life care communities an option for low-income elderly. The agency will continue to explore this option in the upcoming fiscal year. Defined broadly, a life care community is a congregate housing arrangement with on-site health services. At present, the agency's goal is to

determine whether life care can serve as a high-quality, cost-effective means of assisting elderly people to avoid institutionalization. If, as appears likely, life care is a worthwhile alternative, the Department plans to find ways to encourage the development of financially sound life care communities and to offer incentives to developers of those communities to include lower- and middle-income elderly.

- o Improved utilization of congregate housing - In recent years, the Department has assumed a greater role in the selection of state-funded congregate housing sites. Using data compiled by the Office of Health Policy that indicates specific areas of high need, the Department has worked with the Executive Office of Communities and Development to ensure that new congregate housing is targeted at areas where there is documented need for supportive, low-income housing. The Department will continue this work in FY87.

D. More Equitable Financing Mechanisms

Considerable evidence suggests that some individuals are institutionalized despite being capable of remaining in the community, either because they do not have the ready cash to finance their basic daily needs or because they are not able to purchase insurance to cover their noninstitutional care. At present, unlike other ambulatory and acute health services, Medicaid is effectively the insurer of first resort for long-term care services. Currently, Medicaid pays 42% of the national nursing home bill. In stark contrast, Medicare pays only 2%. Private insurers pay only 1% of the national nursing home bill, and provide minimal coverage of noninstitutional long-term care services. In Massachusetts, Medicaid's penetration in the nursing home market is even greater: Medicaid recipients occupy more than 70% of the Commonwealth's nursing home beds and an even larger proportion of its chronic hospital beds.

There are two fundamental weaknesses in this approach to providing long-term care:

- o it is not consistent with the Commonwealth's goal of providing individuals with the maximum opportunity to live in the least restrictive possible setting; and
- o given the prohibitive cost, it is not economically feasible for the Commonwealth to meet the long-term care needs of an increasing and aging elderly population with Medicaid-financed nursing home care.

This degree of government financial penetration into the long-term care system is also risky, since the economic status of the state is variable. Further, upcoming federal deficit reduction efforts may create serious problems for states. Therefore, a more equitable distribution of costs will better ensure the continued financial

viability of the Medicaid program and, more importantly, will provide elders with greater access to all long-term care services. Currently, the Department is addressing this goal as follows:

- o Home equity conversions - In many cases, an elderly individual owns a home and other assets not easily convertible into cash and is therefore unable to use these resources to defray the cost of long-term care. Given this situation, the Department has been supporting arrangements which enable elderly individuals to convert their equity and thereby improve their financial status. Referred to under the umbrella term "home equity conversions", such activities include reverse annuity mortgages, sale-leaseback arrangements and methods of deferring property tax payments. Specifically, the Department plans to join with other state agencies in funding the statewide expansion of a Boston-based organization's (the Senior Home Equity Program) efforts in this area, with a renewed focus on low-income homeowners.
- o Private long-term care insurance - In FY86 and FY87, the Department will increase its attention to private long-term care insurance. The Department will work with other state agencies and the insurance industry to determine how to make long-term care insurance an affordable and viable way of financing health care expenses and will seek to increase the availability and use of this new insurance product.

The public needs to become more aware that Medicare and existing insurance policies have minimal long-term care coverage. Purchasing additional coverage may be the best way to make sure that people can manage the health problems associated with becoming older without incurring enormous expenses or needing to resort to public assistance. Greater availability of long-term care insurance coverage for a range of health services could be an important way of making it possible for people to obtain the assistance they need to avoid nursing home care and remain in their own homes as long as possible.

One additional benefit of long-term care insurance is that it would spread the financial risk of institutionalization across a broader base. This, in turn, could help to promote a more rational long-term care financing system and ensure that the state will remain financially able to assist those with no resources of their own.

E. Better Management of Nursing Home Resources

Despite the state's efforts to promote community care, demographics alone dictate that institutional care will absorb a significant portion of the budget in the future. The goal here is to avoid unnecessary institutionalization and to manage better the institutional services which are necessary. To achieve this:

- o The Department's 22 nurse/social worker teams have been operating across the state, screening in FY85 22,000 individuals seeking placement in a nursing home, assessing them to establish their need for this and/or other long-term care. The prescreening teams assess all Medicaid recipients seeking placement as well as private-paying individuals already in a nursing home who wish to convert to Medicaid benefits. If an individual is deemed appropriate for nursing home care, the team works with discharge planners and nursing home personnel to locate a bed and overcome other barriers to service, and will later conduct monthly follow-up assessments. If a patient does not need nursing home care, the teams will recommend a community service package, make referrals, and conduct monthly follow-ups. In the past year, the teams have diverted numerous elderly nursing home applicants to less intensive institutional or community settings, enabling maximum independence for the individual and reduced reliance on Medicaid.

Three innovations introduced by the prescreening program in FY85 in response to recommendations of an external advisory committee have met with substantial success:

- Delegating approximately 80% of the screening of applicants in acute hospital settings to hospital discharge planners has enabled the prescreening to operate more efficiently and effectively -- by concentrating resources on individuals in the community who are potentially at risk of institutional placement.
- Optional prescreening of private-pay patients seeking admission to nursing homes if they anticipate applying for Medicaid at any time allows elders and their families to make informed choices about the range of long-term care options. In FY85, the program screened 2,700 private-pay elders. Ten percent of those screened received recommendations to not enter nursing homes.
- The program developed and implemented a new assessment instrument. This form promotes a more comprehensive assessment of an individual's care needs.

These activities enhance the management of nursing home resources for Medicaid and non-Medicaid individuals alike.

- o Under the authority of a federal demonstration waiver, the Department contracts with 16 primary care providers to administer medical care to Medicaid recipients in nursing homes through care teams which employ nurse practitioners and physician assistants (NPs/PAs) as primary care givers. The waiver allows the providers to receive Medicaid and Medicare reimbursement for visits by NPs/PAs, which are not ordinarily covered. Experience with the program suggests that the quality of care is improved significantly through a reduction in unnecessary hospitalizations and trips to the emergency room. This results from the flexibility the primary care team has to schedule visits appropriately according to a patient's needs.

In FY85, enrollment increased from 700 to 1,500. Enrollment should reach 2,500 by FY87. The Department is working to obtain an extension of the current waiver beyond the current expiration date of June 30, 1986 and with this permission will expand the scope of the program. The Department expects that HCFA will grant the program at least a one-year extension.

- o Working with the Department of Public Health and the state's Rate Setting Commission, the Department has requested a waiver from the federal Department of Health and Human Services to enable the three agencies to jointly design, implement, and evaluate a prospective case-mix nursing home reimbursement system. A sample of nursing homes would participate in the demonstration project in order to compare this system's operation with the retrospective nursing home reimbursement system currently in use. Among the objectives of this waiver are:

- developing a rate which is correlated directly with the intensity of care patients need;
- providing incentives for cost containment;
- encouraging quality nursing home care;
- providing incentives for adequate access to nursing home beds for publicly-aided clients.

This proposal should encourage nursing homes to admit and maintain more patients with heavier care needs and would institute new quality assurance mechanisms to ensure those "heavy care" patients that are admitted receive appropriate care.

The present, fragmented long-term care system will not be equal to a doubling of the proportion of the state's residents who are elderly. Developing a system which delivers better quality and more cost-effective care is essential. Developing that system will also be difficult, given the number of agencies and providers involved and the importance of providing individually tailored and readily available services. The Department faced similar problems in implementing its ET Choices program. Yet, with considerable and continuing participation and support from the legislature, other state agencies, business, and client advocates, the Department now runs an ET program which has placed more than 23,000 welfare clients into full or part-time unsubsidized jobs and has saved \$69 million in welfare costs. Part of what has made ET successful is agreement on a single goal: providing opportunity for all AFDC clients to receive the help they need to become economically self-sufficient. The Department's view is that the goal for the elderly is similar: to provide the elderly with the opportunity to obtain the services they need to remain in the community and move into nursing homes only if their condition means that they are better served through institutional placement. If, as seems likely, this is a widely shared goal, it should be possible, as it has been with ET, to develop and implement an Elderly Choices System which will benefit enormously both the elderly and the Commonwealth. The Department looks forward to moving the long-term care system in this direction over the next year.

INCREASE IN RATES

A key factor in Medicaid spending is growth in the rates that providers are paid for rendering services. The primary factor driving rate increases is price inflation for goods and services. Other factors which increase rates are costs associated with new services, changes in intensity of service, and administrative requirements.

Increases in the rates paid to providers of Medicaid services have been responsible for most of the growth in Medicaid spending over the past several years. Indeed, despite the recent abrupt decline in general inflation and despite continuing efforts to control costs by both the Department and the Rate Setting Commission, since FY82, Medicaid rates have risen an average of about 8% annually. In FY87, the Department projects that the weighted average provider rate increase will be 6.3%. Because spending in the Medicaid program is projected to exceed \$1.2 billion in FY86, the fiscal impact of a 6.3% inflation rate on that base is in excess of \$75 million. To a large extent, this represents a fixed-cost item that will recur annually. In view of this situation, it is important to note an apparent inconsistency between the system of adjusting provider rates and the system for adjusting recipient grant levels: annual rate increases for providers are virtually guaranteed at the level of inflation and do not appear to be related to the Commonwealth's ability to afford these new costs. Increases in cash grants to cover basic needs of low-income individuals are dependent on the Commonwealth's ability to pay and are not adjusted automatically.

Given the size of the Medicaid budget, rate inflation alone obligates the Department to continue to pursue a Medicaid savings agenda to moderate cost increases. In the absence of a savings agenda, annual cost increases of this magnitude would absorb a significant amount of discretionary expansion monies, thus severely constricting the availability of funds for other critical human service priorities.

Following are a brief description of the methods used to establish Medicaid rates in Massachusetts and a more detailed discussion of the rate issues for major provider types.

Overview of the Rate Setting Commission's Role in Setting Medicaid Rates

In Massachusetts, the Rate Setting Commission (RSC) is legislatively authorized to establish Medicaid payment rates for hospitals, long-term care facilities and noninstitutional providers of health care. The RSC, an independent state agency organizationally located within the Executive Office of Human Services, was established in 1968.

The predominant reimbursement methodology used to determine Medicaid provider reimbursement is cost-based: this type of system recognizes as reimbursable virtually all costs providers incur in delivering care to recipients. At first examination, cost-based reimbursement seems entirely reasonable. The problem with the system is the relative absence

of incentives to contain costs or to promote efficiencies. In fact, because future reimbursement rates are a function of costs incurred in an earlier base year, providers often have an incentive to spend as much as possible.

In accordance with state law, the RSC is currently responsible for establishing fair, reasonable and adequate Medicaid rates. It therefore plays a pivotal role in determining Medicaid reimbursement policy. The Department has no direct control over the Medicaid rate-setting process, yet is the federally authorized "single state agency" or managing agent of the Massachusetts program. This delineation of responsibility has created a problem because the federal government has consistently maintained that the Department, as the designated single state Medicaid agency, is responsible for establishing Medicaid reimbursement policy. Indeed, the federal government has periodically notified the Department that a continuation of the present arrangement may subject the Commonwealth to penalties for lack of compliance with federal regulations. Moreover, this fragmentation periodically interferes with the Department's efforts to control Medicaid costs and manage the Medicaid program.

The Department does not contend that rates should be established arbitrarily. However, the Department believes that reimbursement policy is a legitimate tool not only to control rates but also to encourage more efficient health care practice patterns. The RSC has different organizational objectives and statutory obligations than the Department, and the Commission does not necessarily place the same degree of emphasis on controlling costs while ensuring access that the Department places on those objectives. It should be noted that the incorporation of savings provisions into reimbursement methodologies is neither inconsistent with nor contradictory to the RSC's basic responsibility to establish fair, reasonable and adequate rates -- and there are many instances in which the RSC has taken actions in order to control costs.

In an effort both to prevent federal fiscal sanctions for regulatory non-compliance and to control the rate of expenditure growth, the Department believes that it and the RSC should, at a minimum, pursue the following initiatives:

- o establish a formal memorandum of understanding between the two agencies regarding the responsibilities of each party in establishing Medicaid rates and Medicaid reimbursement policy;
- o develop better administrative procedures to ensure timely and accurate updating of the federally required Medicaid State Plan; timely establishment of new rates to avoid delays in paying providers; and cooperative efforts to expedite processing of provider audit results;

- o improve the link between the RSC rate review process and Department policy and fiscal objectives. More specifically, the two agencies should be required to produce a Medicaid impact statement outlining the likely policy and fiscal results of proposed rate increases and other RSC actions. This impact statement would be jointly approved before being included in the RSC's public notice statement for proposed rate changes and regulations. Since RSC proposals often change after public hearings, the agencies would have to review and, if necessary, revise the impact statement before any rate or regulation change could become final. This approach, which might require changes in state law, is relatively moderate in that it would preserve much of the RSC's current statutorily-mandated independence while simultaneously requiring attention to the potential impact of RSC actions, both in terms of cost and in terms of policy, on the Medicaid program;
- o cooperate in developing initiatives to control Medicaid costs, and promote quality of and access to care. In addition, the RSC should consider developing as an outside limit on rate increase approvals either some indicator of the state's ability to pay or some reasonable measure of inflation (examples include growth in state personal income growth, growth in gross state product, and the establishment of an upper rate limit half the differential between the general consumer price index and the health care consumer price index).

A description of key rate issues for major provider types follows.

ACUTE HOSPITAL SERVICES

Since October 1982, hospital expenditures have been determined pursuant to Chapter 372 of the Acts of 1982, the Commonwealth's hospital cost-containment law. Under Chapter 372, Medicaid acute hospital reimbursement is, for the first time, determined using the same methodology used to determine rates paid by private insurers. As per the terms of a federal waiver demonstration project, Medicaid acute hospital expenditures were governed by the provisions of Chapter 372 through September 1985.

In October 1985, the all-payer system ended, as Medicare began reimbursing hospitals using the Prospective Payment System, which pays a fixed price for each diagnostically-related group (DRG). Chapter 574 of the Acts of 1985 amends Chapter 372 to provide for a continuation of the basic Chapter 372 payment mechanism for the three other major payers--Medicaid, Blue Cross, and the commercial insurers. The other key aspects of this legislation are:

- o Protection, for Medicaid and the other payers, against cost shifting that could result from the Medicare DRG system.
- o Establishment of a statewide uncompensated care pool. This pool ensures that hospitals will be fully reimbursed for bad debt and "free care" and provides that any individual hospital will not be forced to raise its prices (which would put it at a competitive disadvantage) to recover this reimbursement.
- o Provision for the private sector to increase its contribution to bad debt/free care payments by \$20 million to compensate for Medicare's exclusion of free care under the DRG system.
- o Establishment of an advocacy office in the Department of Public Health to protect the rights of Medicare patients.
- o Provision for the Chapter 372 methodology to expire on September 31, 1987; establishment of a study commission on health care financing and delivery to recommend legislation regarding the extent to which hospital prices should be regulated, the method for financing health care services for the uninsured poor, and the subsequent regulatory and financial structure of the delivery system.

Following is a summary both of the major provisions of the original Chapter 372 reimbursement law, and of the major legislative amendments since implementation of the law in October 1982.

MAJOR PROVISIONS OF CHAPTER 372

Before the enactment of Chapter 372, when rates of payment were determined using different methodologies for each of the respective major purchasers of hospital care (Medicaid, Medicare, Blue Cross, and commercial insurance companies), increases in hospital costs were difficult to control because each methodology created different financial

incentives for hospital management. In part, this fueled the rate of growth in Massachusetts hospital costs which were, prior to Chapter 372, reported as up to 40% above the national average.

Consequently, one of the primary purposes of Chapter 372 was to create an acute hospital reimbursement system, both inpatient and outpatient, that would be uniform across payers. As noted above, the provisions of Chapter 372 are intended to create incentives for hospitals to control and reduce costs, so that the high rate of hospital cost increases in the state can be brought under control. Effective control of state health care costs, of which hospitals account for 45%, is particularly important in maintaining a positive economic climate to promote business development.

The new reimbursement system was driven originally by Hospital Agreement-29 (HA-29), negotiated between Blue Cross and the Massachusetts Hospital Association, and was approved by the Rate Setting Commission (RSC) in 1981. All payers paid on the basis of HA-29 approved costs, but with various levels of discounts. The HA-29/Chapter 372 system established a predetermined total budget for a given hospital year based on hospital rate year 1981 costs. This is the Maximum Allowable Cost (MAC). Each year the 1981 base-year costs are adjusted for inflation, volume changes, and exceptions. The hospital receives no more revenues than were budgeted in the MAC. If a hospital spends less than its predetermined budget, it can retain the savings; however, it must absorb costs in excess of its budget. In October 1984, Hospital Agreement-30, also negotiated between Blue Cross and the Massachusetts Hospital Association (MHA) and approved by the RSC, went into effect. HA-30 refined HA-29 and contained the same basic incentives to reduce ancillary utilization and increase outpatient utilization.

Over the course of the budget year, all payers reimburse the hospital at a rate of charges, calculated so as to generate the approved annual MAC level of revenues. At the end of the year there is a settlement process to determine whether the hospital over- or under-generated annual revenues relative to the MAC. Final liability is then allocated among payers.

Medicaid's liability is calculated the same way it is calculated for other payers, by adding the hospital's total charges for the year and then calculating which proportion of these charges represents services provided to Medicaid patients. After the allocation of gross charges between payers, Medicaid's share is discounted using a hospital-specific Medicaid payment ratio. By locking in the 1982 level of Medicaid payment, the original intent of this provision was twofold: to ensure that Medicaid's historical discount continued under the new methodology; and to prohibit Medicaid from implementing independent measures to lower its payments to the hospital industry. (A legislative initiative, enacted in December 1983, resulted in an adjustment to the discount for hospital rate year 1983 services. This nonrecurring adjustment, designed to reflect changes in service mix, resulted in Medicaid costs of \$15 million.)

Two additional provisions important for Medicaid are incorporated into Chapter 372:

- o productivity factor - as per the original agreement, Medicaid and other payers are guaranteed productivity savings in hospital rate year 1986. The productivity factor serves to decrease the growth in acute hospital expenditures to a level slightly below that required for a hospital to receive full reimbursement for inflation, and for the addition of new costs such as those for provision of new services. The purpose of the productivity factor is to encourage hospitals to identify inefficiencies in their operations and to reduce unnecessary costs. In FY85, this productivity factor reduced Medicaid acute hospital expenditures by 2%, or about \$6 million. The productivity factor is expected to yield additional savings of about \$4.8 million in FY86. Cumulatively, by the end of FY86, the Department will have realized about \$21 million in new productivity savings since the enactment of Chapter 372 in October 1982.
- o free care - in order to provide additional financial assistance to hospitals that serve a large number of publicly-aided patients and patients unable to pay for their own hospital care, the Department spends over \$10 million annually in special relief to qualifying hospitals. In the first year of Chapter 372 (the most recent year for which data are available), four hospitals benefited from this provision: Boston City Hospital (\$10.1 million), Cambridge Hospital (\$80,000), Worcester City Hospital (\$80,000), and Somerville Hospital (\$20,000).

A. Medicaid Savings

In addition to the productivity factor described above, Chapter 372 provides a special benefit to the Medicaid program through a method of calculating reimbursement for inpatient services that ensures that the Department pays for only those individual services actually provided to Medicaid recipients. Under the previous hospital reimbursement system, Medicaid reimbursement for hospital inpatient services had been made on a per diem basis. This served to inappropriately inflate Medicaid expenditures because these per diem rates were calculated under the assumption that Medicaid patients receive the same amount of services per day as the average Massachusetts hospital patient. However, the typical Medicaid patient generally needs less intensive services than the typical non-Medicaid patient, because much of the hospital care provided to Medicaid recipients consists of relatively routine care for families. In contrast, the other third-party payers provide coverage for a population containing proportionately more disabled and elderly (Medicare, which also pays most of the hospital costs for Medicaid-eligible elderly and disabled clients), and middle-aged patients (Blue Cross and the commercial insurers). These patients require a more intensive mix of ancillary services. Therefore, savings to Medicaid result because payments are made for only those services rendered to patients rather than an average per diem rate that

reflects costs for all users. This savings provision is termed the "intensity effect."

Hospital rate year 1983 (October 1982 to September 1983) was the first year of the new reimbursement law. Medicaid was guaranteed savings of 5.5% on inpatient services in the first rate year, and this fact was codified into the law. The guarantee was included specifically in the negotiated legislative agreement in recognition of the Department's commitment to generate Medicaid acute hospital savings, as detailed in the Department's FY83 budget recommendations.

During the transitional first year, hospitals were reimbursed on an interim per diem basis for purposes of Medicaid payment. The interim Medicaid per diem was calculated in a manner designed to generate a guaranteed 5.5% savings. This guaranteed 5.5% savings factor combined with the productivity factor resulted in total FY83 savings of about \$11 million, roughly equivalent to the amount the Department had intended to save in FY83 prior to the enactment of Chapter 372.

B. FY84 Medicaid "Intensity Effect" Savings - Chapter 347

Effective October 1983 (the beginning of the second hospital rate year under Chapter 372), Medicaid reimbursement to acute hospitals moved from the transitional system of the interim per diem, with its guaranteed 5.5% savings to Medicaid, to the "true" Chapter 372 reimbursement methodology based exclusively on the percentage of charge for those individual services utilized by Medicaid recipients.

Unlike the first hospital rate year of the new law, Medicaid was not guaranteed "intensity effect" savings in rate year 1984 (October 1983 to September 1984). However, it was generally assumed that Medicaid savings on inpatient services due to the "intensity effect" would total approximately 11% to 12% in 1984. Given that Medicaid had fixed savings of 5.5% in the first rate year of Chapter 372, new savings in rate year 1984 were expected to range from 5.5% to 6.5% (i.e., the difference between the full "intensity effect" in 1984 and the fixed savings in 1983). This translated into projected state FY84 new hospital savings of about \$13 million for the "intensity effect" alone. (The Department also projected FY84 Medicaid new hospital savings of about \$6 million for the productivity factor.)

Early in rate year 1984, however, it became apparent that there was a serious problem with the level of Medicaid reimbursement under the new charge methodology. An analysis conducted by the Rate Setting Commission and the Department indicated that Medicaid "intensity effect" savings in rate year 1984 actually ranged from 22% to 26%, rather than the projected 11% to 12%. This larger than expected "intensity effect" was substantiated by monthly data, which showed that actual Medicaid hospital spending in FY84 was substantially less than originally projected.

The larger than expected "intensity effect" was due to an unintended technical error in the reimbursement methodology. Stated simply, the Medicaid payment rate was calculated incorrectly because lower-cost

administrative days were represented too heavily in the payment formula. Consequently, the Medicaid payment rate was discounted twice for lower intensity -- once for the "intensity effect" and once for the lower-cost administrative days.

This resulted in unintended Medicaid savings for inpatient services of about \$15 million in FY84. Specifically, the Department had originally anticipated FY84 "intensity effect" savings on inpatient services of about \$13 million. The best available data indicate that actual "intensity effect" savings in FY84 were \$28 million, or \$15 million more than anticipated. On a hospital rate year basis, a RSC analysis indicated that unintended Medicaid savings were on the order of \$40 million. (The time differential between state and hospital fiscal years combined with the typical delay between date of service and billing date explains the hospital rate and state fiscal year differential in the estimates of unintended Medicaid savings.)

Since the formula error was an unintended consequence of Chapter 372 as originally enacted, the primary payers and the MHA commenced negotiations in FY84 to amend the legislation. As a result of these negotiations in FY84, an agreement was reached and subsequently translated into legislative language. Enacted into law in December 1984, (Chapter 347 of the Acts of 1984), the amendment included the following major provisions:

- o The state would return to the hospital industry \$15 million for unintended Medicaid savings realized in FY84. \$10 million would be targeted to those hospitals most financially disadvantaged by the error in the Medicaid payment formula, and the remainder would be distributed on a prorated basis.
- o The Medicaid payment ratio in rate year 1985 and beyond was revised to eliminate the formula error. As such, the state would pay on a prorated basis an additional \$40 million to acute hospitals for rate year 1985 services.
- o The legislation stated that hospitals must guarantee to General Relief recipients the full range of medical services they are required to provide to Medicaid recipients. This provision made it likely that General Relief (GR) recipients' access to acute care services would improve considerably. The Department would have spent \$50-\$60 million annually had it instead restored hospital services to the GR population on a fee-for-service basis. The Department had proposed to begin restoring those services on that basis in FY85. GR clients had had no specific entitlement to hospital services since the Department had stopped paying for those services in 1975.

In summary, enactment of this legislation, designed to correct the Medicaid formula error for rate year 1984 and rate year 1985 services, mandated the state to pay a total of an additional \$55 million for hospital rate years 1984 and 1985 together, and to include \$40 million in the subsequent base years. However, in return the state obtained a guarantee of access to hospital services for the

GR population. This guarantee is potentially worth more annually than the \$40 million continuing cost of the Department's agreement to an increase in the hospital rate base.

MAJOR PROVISIONS OF CHAPTER 574

In the summer of 1985 the state applied to the Health Care Financing Administration for an extension of the waiver of Medicare reimbursement principles in order to allow continuation of the Massachusetts all-payer hospital reimbursement system. However, this waiver application was not supported by either the MHA or by HCFA. Faced with this lack of support, legislation was negotiated which enabled the transition for Medicare to the prospective payment DRG system, and turned the Chapter 372 system from a four payer system into a three payer system by wrapping it around the DRG system.

Under the Medicare DRG system, each patient is classified into one of 470 DRGs, where the classification depends on principal and secondary diagnoses, and on the type of surgical procedure, if any, performed. The hospital is paid a fixed predetermined amount for each patient in a DRG. Under this system, as under the Chapter 372 system, hospitals have an incentive to encourage physicians to discharge patients as soon as possible and to admit, within each DRG, relatively healthier patients. However, the incentives in these directions are stronger under the DRG system than under the Chapter 372 system, and concern about adverse effects on Medicare beneficiaries led to the establishment, in Chapter 574, of an advocacy office in the Department of Public Health to act as an ombudsman for the protection of the rights of the elderly.

The following is a more detailed description of two of the major provisions of the new hospital reimbursement law.

A. Cost Shifting

If the Chapter 372 system had been left unchanged, Medicare's DRG payment system could have resulted in hospitals shifting costs to the other payers. One of the major concerns of the non-Medicare payers was to draft an amendment to Chapter 372 which would prevent this cost shifting. Under the Chapter 372 system, hospitals were able to shift costs from one payer to another by lowering charges for some services and raising charges for other services, as long as total charges were below an approved level. For example, if a hospital lowered charges in oncology services and raised charges in obstetric services, Medicare's payments would decrease and the payments of other payers would increase. While this form of cost shifting was possible under Chapter 372 and was occurring to some extent, the incentives to cost shift were limited: although Medicare paid at slightly lower rates than Blue Cross and the commercial insurers, the differential was not large enough to cause hospitals to massively shift charges away from Medicare intensive services.

With the advent of the DRG system for Medicare however, this situation changed markedly. Medicare's payment for each admission

now is entirely independent of charges, and hospitals have a strong incentive to shift charges away from Medicare intensive services such as oncology. In order to prevent this cost shifting, Chapter 574 establishes new controls on non-Medicare gross patient service revenue. These controls not only insulate Medicaid, Blue Cross, and the commercial insurers against cost shifting made possible by Medicare's transition to the DRG system, they also protect against the cost shifting away from Medicare that was occurring under Chapter 372.

B. Uncompensated Care Pool

Under Chapter 372, Medicare contributed approximately \$20 million to free care payments; the new DRG system, however, makes no explicit allowance for such payments. Chapter 574 incorporates an agreement made by the private payers (Blue Cross and the commercial insurers) to increase their free care payments by the \$20 million that Medicare no longer covers. Medicaid continues, as under Chapter 372, to pay a share of free care at hospitals with large numbers of publicly aided and uninsured patients.

In addition to providing that the private payers will make an additional \$20 million in free care payments, Chapter 574 changes the method by which hospitals receive reimbursement for bad debt and free care by establishing an uncompensated care pool. The Chapter 372 system allowed a hospital to raise its prices above the level needed to recover patient care costs in order to cover the costs of bad debt and free care. Under this system, hospitals with small amounts of bad debt and free care had relatively low prices, while hospitals with large amounts of bad debt and free care had relatively high prices. On average, charges were approximately 8.5% higher than they would have been if hospitals had no bad debt and free care, but the bad debt/free care "mark-up" varied considerably by hospital.

While this system had the advantage of assuring hospitals that they could be paid for providing free care, it had the disadvantage of forcing them to raise their prices, putting them at a competitive disadvantage, in order to receive free care reimbursement. The uncompensated care pool established by Chapter 574 provides for all hospitals in the state to raise their prices a uniform amount above the level needed to recover patient care costs. The hospitals which raise more money through this uniform markup than they need to cover their own bad debt/free care costs will pay the excess into the "pool" (or bank account administered by Blue Cross under direction from the Rate Setting Commission), and hospitals which raise less money through this uniform markup than they need to cover their bad debt/free care costs will receive payments from the pool.

This uncompensated care pool reduces the financial disincentives to hospitals of serving the uninsured poor by insuring that hospitals will receive reimbursement for these services without raising their prices. In addition, the pool makes more explicit the monies that are used to pay for care for the uninsured poor. The pool should enable the adoption of broader based, more equitable and more efficient solutions to the problem of how to finance and deliver health care services to the uninsured poor in the future.

CHRONIC DISEASE AND REHABILITATION HOSPITAL RATES

The Rate Setting Commission (RSC) sets rates for the 30 chronic disease and rehabilitation hospitals (CDRHs) which participate in the Medicaid program. Twenty-four CDRH facilities are funded directly out of the Department's Medicaid account, and in FY85 the Department spent about \$141 million for services delivered in these facilities. The other six CDRHs are operated by the Department of Public Health (DPH), and receive annual line-item appropriations from the state legislature. These state facilities recover federal Medicaid revenue for services to Medicaid-eligible recipients; the Department processes these claims for DPH.

Chronic hospitals have been the focus of considerable debate over the last decade. While there are almost 5,900 CDRH beds in Massachusetts, approximately one third of the nationwide total, there is no evidence to suggest that the CDRH system has developed in a rational way or in response to a direct need for this intensive level of care. In fact, the State Health Plan indicates that Massachusetts requires 6.3 CDRH beds per 1,000 elderly, or approximately 4,700 beds statewide. At present, Massachusetts has a supply equivalent to 7.8 CDRH beds per 1,000 elderly, translating into an oversupply of approximately 1,100 beds. As a recent DPH study documented, almost 45% of the CDRH beds are filled with patients who require less intensive care, usually nursing home care. Given that Medicaid is the primary payor of CDRH hospital services (paying for an estimated 70% of the state's CDRH beds) and given the significant cost differential between CDRH and nursing homes, the oversupply of beds has significant fiscal implications for the state, probably causing more than \$10 million in unnecessary spending annually.

FY87 CDRH ISSUES

In addition to this resource-allocation issue, the following are three important CDRH issues for FY86 and FY87.

A. Reimbursement Methodology

Prior to October, 1985, nonacute hospitals, including CDRHs, were reimbursed on a per diem basis. A given year's all-inclusive rate was calculated using actual costs during a base year, adding the appropriate number of years of inflation and then dividing allowable costs by total patient days. Certain components of this rate were reduced to establish lower rates for hospital patients who only required a nursing home level of care (administrative day patients). This system provided little or no incentives for hospitals to practice any form of cost control. The methodology not only recognized all allowable base year costs, but gave providers an incentive to make each year's spending as high as possible, since those costs were then recognized in the base for subsequent rates.

This retrospective reimbursement methodology has been replaced by a new prospective methodology which became effective October 1, 1985. The new methodology differs from the prior one in several ways.

- o Hospital allowable costs will always be determined from a base year that has been fixed at FY84. Base year costs screens will limit these costs by disallowing excessive costs. Adjustments will be allowed for cost increases or decreases which may result from changes in volume, case-mix, inflation, or other factors.
- o A second major revision is the change from a per diem to a charge based system, which is more responsive to a hospital's changing case mix. Under the prior system, a hospital's reimbursement for each patient did not vary with the level of services utilized, creating perverse incentives to reduce admissions of heavy-care patients or to inappropriately restrict resource use by these patients. Under the new system, a payment on account factor (PAF), which is the proportion of hospital charges which are allowable for Medicaid reimbursement, will be calculated for each hospital. Medicaid will pay approved charges multiplied by the PAF.

A charge-based billing system will not be implemented for all of the CDRHs until July 1, 1986. In the current rate year, Medicaid will reimburse each hospital with a single daily inpatient rate as it has done under the original methodology. The weighted average chronic hospital rate for FY85 was \$182.33 per day and for FY86 (with 59% of the hospital per diems calculated under the new methodology) is \$191.35 per day, representing about a 5% increase.

- o A final feature of the new system is a revision in the payment mechanism for administrative day (AD) patients. These patients do not require the specialized and comprehensive services of a CDRH, and could be served more appropriately in nursing homes, rest homes, or the community. There will no longer be separate, reduced rates for AD services. Under the new system all hospital patients, whether hospital or AD level, will be reimbursed through the charge-based system where payment levels reflect the level of services received by an individual patient. Since AD patients generally require less intensive care, they will incur fewer and, hence, lower charges than hospital level patients.

B. Appropriate Classification of Facilities

As documented by staff of the Executive Office of Human Services (EOHS) in a study that compared CDRHs by utilization characteristics, there is a broad degree of diversity among these facilities. For instance, length of stay in 1982 ranged from 37 days to 6.1 years; Medicaid reimbursement as a percentage of total revenue ranged from 13% to 99%; and patients placed inappropriately in CDRHs ranged from 0% to 94%.

This diversity, reflective of the array of missions and services among facilities, has consistently defied government's efforts to control costs and ensure quality through a single rate methodology.

In its analysis, EOHS formulated separate bed-need methodologies for rehabilitation and for chronic hospital services. EOHS grouped these diverse facilities into types providing rehabilitative, chronic, and nursing home levels of care. Each group can be demonstrated as offering services which differ from types of care rendered by the other groups. These formulae, if adopted into the State Health Plan, would call for an increase in rehabilitation beds and a decrease in chronic beds.

This analysis of the dissimilarities among these facilities demonstrates the difficulties resulting from licensing, regulating, and reimbursing these providers under the single rubric of chronic disease and rehabilitation hospitals. In order to improve the cost effectiveness of the chronic/rehabilitation hospital system while providing necessary care, an important step is to recognize distinct categories among the facilities for licensure and reimbursement purposes as categorized in the report. Consistent with this policy initiative, during FY85, two CDRH's were "downgraded" to nursing homes and their rates now reflect the lower intensity of services provided to the patients who reside there.

FY87 ALTERNATIVES

In response to the problems outlined above, the Department is recommending the following alternatives:

A. Closure/Consolidation of CDRH Facilities

It has been documented that hospital facilities achieve a basic level of efficiency at 90% capacity. Given this direct correlation, the state should rigorously examine the feasibility of closure and/or consolidation of underutilized or inappropriately utilized state-owned CDRHs. In making these decisions, the state would need to place a high premium on quality-of-care factors, in particular the availability of appropriate placements in nearby facilities and the state's ability to ensure that patients who are transferred continue to receive quality care. In addition, the economic benefits that state CDRHs provide as employers of community residents are substantial. Ideally, the former chronic hospitals, or at least the land they occupy, could house revenue and job-producing enterprises of other kinds. Because state CDRHs are funded through DPH appropriations, savings from closure/consolidation would be reflected in those accounts rather than in the Department of Public Welfare's budget.

B. Utilization Review

In FY84, the Department established a CDRH utilization review (UR) program, in part to determine whether hospitals were billing the Department at the appropriate levels of care. Excepting six hospitals who have brought suit against the Department concerning both its UR authority and the level-of-care criteria, each CDRH was subject to two on-site reviews in FY84. The primary purpose of the first review was to educate each hospital on the appropriate application of the governing regulations, rather than to maximize Department recovery for inappropriate billing procedures. The second review, however, focused more specifically on compliance monitoring and yielded a 60% average rate of disagreement between the Department and the hospital for patients billed for at the chronic level of care. Recovery of at least \$1 million of the overpayments implicit in that level of disagreement should occur in FY86.

Recovery will be more difficult if the current litigation is settled unfavorably to the Department and AD rates and/or UR authority are judged to be invalid.

In addition to direct recoupment of overpayments, UR activity in FY86 and FY87 should result in continuing savings through the encouragement of appropriate billing by providers.

NURSING HOME RATES

The Rate Setting Commission (RSC) sets rates for the 525 nursing homes participating in the Medicaid program. Rates are set according to the intensity of medical services each facility provides. Rates in FY87 will range from an average of \$43 per day for patients in Level III intermediate care facility (ICF) beds to an average of \$61 per day for patients in more care-intense Level I and II skilled nursing facility (SNF) beds. Medicaid is the single largest payer of nursing home services. In FY86, the Department spent about \$450 million for nursing home services, representing about 38% of the total budget.

The Massachusetts nursing home bed supply and Medicaid expenditure distribution divide as follows:

Massachusetts Nursing Home Bed Supply and Medicaid Expenditure Distribution

<u>Level</u>	<u># of Beds</u>	<u>Medicaid Occupancy</u>		<u>FY85 Medicaid Expenditures (\$M)</u>
I & II	20,253	57%	11,544	\$189.1
<u>III</u>	<u>26,746</u>	<u>79%</u>	<u>21,129</u>	<u>260.2</u>
TOTAL	46,999	70%	32,673	\$449.3

Individuals requiring primarily non-medical assistance receive Level IV or rest home care. The Medicaid program does not pay for Level IV services. They are funded through the Department's Supplemental Security Income program.

The RSC's current retrospective cost-based nursing home rate methodology operates as follows: each participating facility receives an interim per diem rate based upon the prior year's operating costs (nursing and variable costs), an administration and policy planning allowance, short-term financing costs, a return on equity (the owner's investment in the facility), and a cost adjustment factor to reflect projected changes in economic conditions (inflation) for the interim rate year. The interim per diem rate covers projected operating costs for the rate year. To determine the final rate for a facility, the RSC examines actual costs during a given calendar year. When interim rates have provided insufficient reimbursement, the facility borrows money to make up the deficit. The state then repays the difference in the facility's final rate, usually determined two years after the close of the rate year. If the interim rate has provided excessive reimbursement, the nursing home must repay the excess.

A. Regulatory and Program Changes

In the 1984-1985 period, the RSC enacted a series of regulatory changes which served to refine the retrospective cost-based reimbursement system. Two major changes, supported by the Department, were the adoption of a more valid methodology for predicting inflation and a reduction in the return on equity multiplier.

- o Improved Methodology for Forecasting Inflation - The most significant regulatory change occurring in 1984 was the adoption of a more accurate model for forecasting inflation. The former method of forecasting inflation was essentially based on a ten-year rolling average of previous years' price inflation, weighted by cost category. This method was found to be neither reliable nor valid for projecting costs because a historical average inappropriately rewarded providers during low inflationary rate periods and inappropriately penalized providers during high inflationary rate periods. Application of the new method provided the RSC with a more precise indicator to project inflation by using a proxy which is consistently fair to both the providers and the Department.
- o Reduced Return on Equity - Proprietary nursing homes receive, as a component of their rate, a return on the value of that part of the home which is owned debt free. This return is based on the average monthly rate of interest of the hospital insurance trust fund. However, in an effort to encourage long-term ownership of facilities, the RSC adjusts this base upward by an RSC-established multiplier. The result has been a guaranteed return on equity above the level of return available in the general financial markets. Consistent with an initiative proposed by the federal government and supported by the Department, in 1984, the RSC, after originally proposing elimination of the multiplier, reduced the multiplier used in calculating the return on equity from 125% to 112%. This reduction resulted in about \$1.5 million in savings.

Despite the reduction in 1984, nursing home proprietors still receive a guaranteed return on equity of about 14.5%, which exceeds the return available in the general financial market. With the return on equity being only one of several ways for proprietary facilities to generate a profit, the Department finds little justification for providing a higher level of return than is available in the general financial market. The Department therefore continues to support eliminating the multiplier. Elimination of the multiplier would save the Department up to \$2 million annually, while still providing nursing home proprietors with a rate of return consistent with those of other low risk long-term investments (about 11% in 1985). The average impact of this change on each proprietary nursing home would be approximately \$4,000.

B. Prospective Reimbursement

The present system of nursing home reimbursement includes both prospective and retrospective elements resulting in an interim and then a final rate. Both providers and the Department have raised questions concerning the usefulness of this methodology. In 1985, working closely with the Department of Public Health and the state's Rate Setting Commission, the Department has requested a waiver from the federal Department of Health and Human Services to enable the three agencies to jointly design, implement, and evaluate a prospective case-mix nursing home reimbursement system for a sample of nursing homes in order to compare its operation with the retrospective nursing home reimbursement system currently in use. Among the objectives of this waiver are:

- o linking Medicaid nursing home expenditures more closely to care actually required by patients;
- o providing incentives for cost containment;
- o encouraging quality nursing home care; and
- o providing incentives for adequate access to nursing home beds for publicly-aided clients.

The Department supports the concept of setting nursing home rates through a prospective methodology. Outlined briefly below is a summary of the advantages and disadvantages as well as some of the key financial and quality issues that need to be addressed in order to ensure an equitable methodology. A prospective reimbursement system by definition contains two basic features: (i) rates of payment are established in advance for the coming year; and (ii) providers must operate within relatively fixed budgets. Prospective reimbursement has the following advantages:

- o Improved facility cost-efficiency - as noted above, the present system of nursing home reimbursement includes both prospective and retrospective elements. Not knowing what their actual revenue per patient will be makes it difficult for facilities to do accurate financial planning. Because rates of payment are fixed in advance under a prospective system, providers have an incentive to be more cost conscious in day-to-day spending and in long-term expenditure planning.
- o Elimination of the need for short-term loans - the fact that providers will be required to limit their spending to the budgeted amount eliminates the incentive for securing high cost short-term loans to cover working capital needs. Thus, the Department would no longer have to reimburse facilities for the interest on their loans.
- o Elimination of retroactive collections - retroactive collections, which become necessary when a facility's final rate is lower than its interim rate, have always been

difficult to make because these homes are more likely to be in financial distress. Reducing current year reimbursement in order to recover prior year overpayments has limits since facilities need enough funds to cover necessary operating costs. Prospective rates reduce the need for retroactive collections and will reduce the funds lost to the Department if facilities which owe funds enter bankruptcy.

- o Improvement in program administration and reduction in administrative appeals - prospective reimbursement would eliminate the need to calculate final rates, a cumbersome and time consuming procedure. In addition, the attendant reduction in the number of administrative appeals will provide the RSC with resources it needs to complete more and better nursing home financial audits.

The Department recognizes that conversion to a prospective rate system requires a tremendous amount of administrative work, primarily by the RSC. Though the Department supports such a system, both quality of care and financial implications must be carefully monitored and addressed in the development of the regulation. Two key concerns include:

- o Quality - the incentive to control costs must not compromise quality of care, specifically the reduction of essential nursing services. One way to safeguard patient care is to implement a matrix for nursing and variable costs that emphasizes access and quality. Also, given a predetermined fixed payment, providers may try to admit patients who require a less intensive service package. Thus, case-mix needs to be monitored closely to ensure that facilities are not excluding patients needing more intensive care. The results of the prospective case-mix nursing home reimbursement project, if that proposal is approved by the federal government, could provide a sound foundation for ensuring quality.
- o Appropriate base year - in order to promote efficiency, a base year must be chosen that is representative of the industry's legitimate costs, but does not saddle the state with nonrecurring cost items. Also, the RSC needs to determine whether the base year will be fixed for a set period or will be moved forward annually. This decision can significantly affect the total amount of funds expended for nursing home services. For instance, if there is no sharing of savings between the provider and the state, establishment of rates predicated on a permanent base year effectively guarantees that the provider will reap all of the benefits from efficiencies achieved during the entire period. However, if the base year is updated annually, the state would realize savings to the extent that the provider has effected cost reductions in the previous year because savings would be incorporated into the new base.

NONINSTITUTIONAL PROGRAMS

Description and Scope of Noninstitutional Services

Noninstitutional services -- community-based medical care -- encompass a wide range of procedures delivered by physicians, pharmacists, dentists, optometrists and opticians, podiatrists, private duty nurses, therapists, specialty clinics, mental health programs, community health centers, home health agencies, adult day health providers, transportation providers, and those programs designed to pay for medical goods and supplies, including durable medical equipment, orthotics, and prosthetics. An assortment of noninstitutional long-term care providers, such as the independent living centers, day habilitation providers, and adult foster care programs, also provide care in community-based sites. In all, there are nearly 40 different noninstitutional provider types in the Medicaid program. The cost of these services in FY85 amounted to about \$250 million, or about 22% of the total Medicaid budget.

FY85 Medicaid Spending for the Major Noninstitutional Programs

<u>Program</u>	<u>\$M</u>	<u>% of Total Budget</u>
Pharmacy	65	5.6%
Physician	51	4.4%
Home Health	31	2.7%
Dentist	20	1.7%
Transportation	14	1.2%
Medical Supplies	14	1.2%
Therapy (Physical, Speech)	7	0.6%
Laboratory	4	0.3%
Radiology	4	0.3%

Rate Setting Process

The RSC has the sole authority to set the Medicaid rates for all noninstitutional providers. Generally, the rate setting process incorporates an annual review. The RSC evaluates the procedure-specific level of reimbursement for each of the individual noninstitutional provider types and adjusts the rates for inflation and other factors. All proposed revisions are published in regional newspapers and are made available to interested parties through official public notices. A public hearing of the RSC is held on each proposal. The rate setting process has remained basically unchanged for several years.

Most of the annual reviews result in rate adjustments. Over the past year, fees for the most part have continued to rise. However, in several cases, the amount of increase has been limited to inflation. On average, in FY85, Medicaid rates for noninstitutional services rose by about 6%. While the growth in the level of reimbursement represents increasing costs, Department participation in the rate setting process helped ensure that rates did not exceed reasonable levels. The Department, through this effort, also has avoided costs, particularly costs associated with retroactive rates and alternative methodologies, that it might otherwise have incurred.

Since the beginning of FY84 until the present, the Department has often supported moderate rate increases for noninstitutional services. These services are often more cost effective than hospital outpatient department-based alternatives. Physician services and several other independent practitioner programs have received particular attention in an effort to ensure participation by those providers in the Medicaid program.

Major Regulatory Changes and Program Initiatives

o Recent Rate Setting Activity

Since the beginning of calendar year 1985, more than twenty rate reviews of noninstitutional services have been conducted by the RSC. The rate reviews, and subsequent public hearings, have resulted in revised fees for twenty-five Medicaid-covered noninstitutional programs. With the exception of a few individual procedures, virtually all of the rate reviews resulted in increased fees. A few noninstitutional programs, including community health center medical visits, dental services, family planning, independent living, private duty nursing, and psychiatric day treatment, received relatively high increases, ranging from 10.7% to 22.9%.

The most significant changes in rate setting methodology occurred in the community health center and orthotics and prosthetics programs. Community health center (CHC) rates were adjusted by an annual inflation factor of 4.7%. However, other changes, most notably the elimination of non-medical nursing time from the CHC productivity factor, were also made and resulted in a projected effective increase of between 15% and 20%. The revised community health center methodology went into effect on July 1, 1985. In the area of orthotics and prosthetics, a completely new pricing methodology was implemented by the RSC. In the past, the Department paid charges for all orthotic devices and most prosthetic devices. The new pricing methodology ties reimbursement to the actual acquisition cost of materials and the actual professional time and technical labor devoted to each service.

o Physician Services

Since FY84, the Department has demonstrated a commitment to improving all aspects of the physician services program. While the Department historically has been opposed to substantial across-the-board increases in physician reimbursement on the grounds that increases for some physician specialties are unjustified, the incentives inherent in the fee structure that existed prior to mid-FY84 interfered with the Department's efforts to encourage use of community providers. Thus, in an effort to improve access to physician services through increased provider participation in the Medicaid program, the Department since that time has supported a series of changes to the regulations governing physicians' fees. In particular, the FY84 RSC regulations resulted in a weighted average rate increase of nearly \$10 for a routine office visit, which rose from \$11.50 per visit to \$21.00 per visit. The increase in the Medicaid rates for primary care put Medicaid office visit fees on a par with average usual and customary non-Medicaid fees statewide. The FY84 changes not only raised the rates for primary care services, but rates for other procedures as well; on average, physicians' fees for all Medicaid services increased by 16%.

The FY84 regulatory changes also established new procedure code definitions for office visits. The new procedure code descriptions for primary care helped to alleviate the billing and reporting difficulties which Medicaid physicians historically had experienced. The new definitions are clearer and afford more precision in the use of procedure codes. The revisions have proved useful to providers and have allowed the Department to better control and monitor utilization. Moreover, the improved definitions, new fees, and other regulatory controls should encourage the delivery of medical care in cost-efficient, community-based delivery sites, such as physicians' offices, thereby resulting in better access for recipients and savings to the Department.

In FY85, a global fee, or all-inclusive rate per client, was established as an optional reimbursement mechanism for obstetrical care. The creation of a global fee provided an alternative to billing for individual prenatal visits, delivery, and postpartum care. Use of a global fee permits physicians to bill just once for the entire package of services, significantly reducing the paperwork and billing costs normally associated with these services. The global fee, then, effectively increases the aggregate unit value of the rate, and acts as a financial incentive to attract Obstetrical and Gynecological (OB/GYN) provider participation in the Medicaid program. Before the end of FY86, the Department anticipates that a major increase in the current global fee of \$508 will occur. The increase is expected to bring the Medicaid global fee up to the same level of reimbursement as is provided by other insurers. It also is expected to take into account the rising costs associated with OB/GYN malpractice insurance. The anticipated increase has a broad base of support in state government and is widely supported in the provider community. In a related effort also intended to increase OB/GYN provider participation, at the Department's request, the RSC in

August 1985 restored to pre-1983 levels the rates for all obstetrical and gynecological surgical procedures.

Concurrent with these rate actions, the Department over the course of the past two years has streamlined its administrative regulations in response to concerns raised by the provider community. The Department revised the Medicaid enrollment application, making it clearer and easier to understand; offered training and technical assistance to billing staff in physicians' offices to familiarize providers with the Medicaid billing process and to teach them how to solve billing problems; and revised the audit process in consultation with the Massachusetts Medical Society in order to refine the selection procedure and decrease the burden on physicians' offices.

During FY86 and FY87, the Department will continue to cooperate with the RSC in an extensive review of more than one hundred selected surgical procedures. The purposes of the review is to evaluate, update and establish new levels of reimbursement for various highly utilized physician services. New rates will be adopted in either late FY86 or early next fiscal year. By encouraging physicians to see Medicaid clients in office settings, these rate changes should help to shift health care out of expensive hospital settings, thereby resulting in savings considerably in excess of the cost of the physician rate increase.

FY87 Program Goals

The Department's key noninstitutional program goals for FY87 include:

- o continued improvement in the area of physician, especially OB/GYN, participation in the Medicaid program, achieved in part through a new fee schedule to be established by the RSC and the incorporation of increased medical malpractice insurance costs into the rate setting methodology;
- o managing the growing cost of home health agency services which currently stems from the trend toward shorter inpatient hospitalization; and
- o encouragement of increased participation by some providers, including dentists and nurse practitioners.

FY87 REQUEST

The Department's FY87 Medicaid request is \$1.237 billion. This request is primarily the net result of cost increases from changes in provider rates and in utilization, less \$42.25 million in projected new cost reductions resulting from savings initiatives and less \$55 million in nonrecurring acute hospital settlement obligations. The aggregate caseload, although it will fluctuate by category, is expected to remain essentially constant in FY87. The components of the spending forecast are outlined below.

Provider Rate Increases

Every year, inflation in health care costs is the major factor in the growth of the Medicaid budget. It is also the factor over which the Department has the least control. The FY87 request includes \$74.1 million in rate inflation, reflecting a 6.3% weighted average increase to providers. The table below indicates projected FY87 rate increases by provider type. The projection for each provider type is adjusted for the effects of partial year increases.

Projected FY87 Rate Increase and Expenditure Distribution
by Provider Type

<u>Provider Type</u>	<u>Projected % Rate Increase</u>	<u>FY87 Expenditures (\$M)</u>	<u>Percent of Total Projected Expenditures</u>
Inpatient Hospital	6.9%	\$243.5	19.7%
Skilled Nursing Facility	5.9%	206.8	16.7%
Intermediate Care Facility	5.9%	283.6	22.9%
Chronic Hospital	6.4%	154.9	12.5%
Outpatient Hospital	6.9%	118.1	9.5%
Pharmacy	5.7%	71.0	5.7%
Physician	7.3%	60.0	4.9%
Dentist	6.3%	31.0	2.5%
Home Health	5.3%	21.7	1.8%
<u>Other</u>	<u>6.1%</u>	<u>46.5</u>	<u>3.8%</u>
Total	6.3%	\$1,237.1	100.0%

Nursing Home Retroactive Payments

Each year, the Rate Setting Commission establishes a final reimbursement rate for each nursing home facility that represents the differential between the interim reimbursement provided during the rate year and actual allowable costs. With the final rate being established two years after the date of service, the Department discharges this fiscal obligation through a retroactive payment. The nursing home retroactive payments for FY87 are projected at \$27.5 million.

Utilization

In FY87, three utilization factors will affect expenditures:

- o expansion of alternatives to institutional long-term care. These alternatives programs include home health, adult day health, adult foster care, and independent living. Their expansion is a crucial component of the Department's efforts to reduce inappropriate utilization of nursing home care. Expansion of the alternative programs is projected at \$5.1 million in FY87.
- o increased use of services among the under-21 population, resulting from Project Good Health, the Commonwealth's early and periodic screening, diagnosis, and treatment program. Enrollment of recipients in this federally required preventive health program initially often increases expenditures because the program prescribes regular visits to a physician. New enrollment in FY87 will result in a \$1 million increase in utilization of Medicaid services paid for through the Medicaid account. The activities that encourage recipient enrollment are funded through the Project Good Health account (4400-1400).
- o extended coverage of psychiatric services to recipients under age 21. Outside language of the Commonwealth's FY85 budget directs the Department to include psychiatric institutional services for the recipients under age 21 as a Medicaid-reimbursable service. Prior to FY85, this service was Medicaid-reimbursable only in general acute hospitals. Coverage is now extended to services provided by public and private psychiatric hospitals. The projected additional FY87 cost of this benefit is \$1 million.

Caseload

The Department projects that the Medicaid caseload will increase slightly (less than 1%) in FY87. The following table indicates the percentage change in caseload from the previous fiscal year for each category of assistance, and the percentage of FY87 Medicaid expenditures by category.

FY87 Medicaid Caseload by Category of Assistance

<u>Category</u>	<u>Projected Average FY87 Caseload</u>	<u>% Change From FY86</u>	<u>Percent of FY87 Expenditures</u>
SSI-Old Age	51,857	(1.8%)	9.0%
SSI-Disabled	55,858	2.1	15.5%
AFDC	84,882	(0.6%)	21.5%
MA-Old Age	38,860	1.0%	42.3%
MA-Disabled	8,620	0.5%	8.2%
MA-AFDC*	8,853	2.5%	2.0%
MA-Under 21	<u>10,119</u>	<u>3.1%</u>	<u>1.5%</u>
Total Weighted Average Change	259,049	0.2%	100.0%

* Includes ex-AFDC cases closed off of AFDC because of excess income; these families receive extended Medicaid coverage.

The size of the overall Medicaid caseload is expected to remain virtually unchanged in FY87. However, the composition will vary by category of assistance. Specifically, the Medicaid-only categories are expected to increase due to: (i) a proposed 10% AFDC payment standard increase which would result in an increase in the MA-only eligibility standards; and (ii) a 15-month extension of Medicaid coverage to about 1,000 families who have become ineligible for AFDC due to an OBRA eligibility policy change. A 9-month extension is required by the federal Deficit Reduction Act of 1984; the Commonwealth has chosen the option to extend the benefit by an additional 6 months, to 15 months.

In part because of the Department's Employment and Training program, the AFDC caseload will decline. The SSI caseloads will continue in accordance with past trends. Specifically, the SSI-Disabled caseload will increase slightly. Despite an increased number of elderly in the Commonwealth, SSI-Old Age will decline because other pensions, particularly Social Security, are increasing more rapidly than the SSI standards.

Savings

Through the initiatives listed in the following chart, the Department will achieve a \$42.25 million increase in savings in FY87.

FY87 SAVINGS AGENDA

<u>Initiative</u>	<u>Projected FY87 Savings (\$M)</u>
Third-Party Liability	\$13.65
Review of Provider Practice Patterns	10.00
Provider Review and Sanctions	8.00
MMIS Edits/Audits	4.60
Acute Hospital Preadmission Screening	2.50
Legislation	2.00
<u>Chapter 372</u>	<u>1.50</u>
TOTAL	\$42.25

SPECIAL REPORT: HEALTH CHOICES FOR FAMILIES AND CHILDREN

INTRODUCTION

Beginning in FY87, the Department is proposing to begin restructuring the existing Medicaid program from a predominantly fee-for-service based system, which does not ensure appropriate utilization of or access to health care services, to a three-pronged system which will be designed to better ensure comprehensive, high-quality care delivered in a more cost-effective fashion.

The Medicaid fee-for-service system, where the Department pays a fee for each service clients receive, results in the following fundamental inequities for low-income people:

- o perpetuation of dual-care system - while a rapidly increasing portion of the general population has the opportunity and has affirmatively chosen to receive its health care through new, alternative delivery systems such as health maintenance organizations, poor people effectively do not have comparable freedom of choice.
- o limited access to primary care physicians/overreliance on teaching hospitals for ambulatory care - many poor families cannot get access to primary and specialty care physicians in part because these providers do not want to participate in Medicaid's fee-for-service system. Consequently, many poor people rely on tertiary acute hospitals for routine primary care.
- o lack of quality assurance - even in situations where the recipient is able to secure a personal physician, the fee-for-service system does not ensure comprehensive and continuing care, in part due to the absence of quality assurance monitoring.
- o disincentive for prudent buying - the piecemeal purchase of any set of products, including health care, is inefficient; it prevents the buyer -- the state -- from using its economic leverage to secure the most competitive price.
- o economic disadvantages for clients - because the fee-for-service system permits inappropriate and excessive utilization of services, and because the state purchases care piecemeal, the system results in a severe misallocation of resources, absorbing funds that could be used to address other client needs.

Medicaid reform is not a new idea. Unfortunately, many prior reform efforts in Massachusetts focused primarily on generating short-term savings and gave little attention to the needs of the clients. Some of these reforms correctly engendered stiff resistance from the recipient and provider communities -- and the reforms failed. It does not follow, however, that ensuring the provision of improved health care for low-income people and achieving aggregate system efficiencies are contradictory, or mutually exclusive, goals. In developing this proposal, the Department has placed a premium on meeting the needs of clients through the proposed establishment of a health delivery system which mirrors the health care choices available to non-poor citizens of the Commonwealth and which would share potential program savings with clients directly.

The proposed HEALTH CHOICES program initially would be offered to low-income families (AFDC-related recipients) and would provide them with a real opportunity to select their health care coverage from among one of the following three plans:

- o Basic Medicaid - continued full coverage of the existing comprehensive package of services, through a revamped fee-for-service reimbursement system which incorporates generally accepted utilization control measures.
- o Coordinated Health Program - a single primary care provider (i.e., community health center, health maintenance organization, or physician) provides or authorizes all necessary health care services.
- o Private Insurance Program - under a negotiated agreement between the state and one or more prospective private insurers, the third health care option for Medicaid-eligible families would be a private insurance plan such as Blue Cross Master Health Plus or Prudential Care.

The Department believes strongly that the proposed restructuring of the Medicaid program is necessary to ensure that recipients are able to secure high-quality health care at a reasonable cost to the state. Through the introduction of fiscal and program incentives currently available to the general population, the CHOICES proposal addresses responsibly the major inherent flaws in the current Medicaid system:

- o Eliminates dual-care system - viewed objectively, implementation of the HEALTH CHOICES program would ensure, perhaps for the first time, that poor people have a legitimate opportunity to choose from the same broad menu of traditional and alternative health care options available to people of means.
- o Efficiency/prudent buyer - as presently conceived, the proposal is consistent with current efforts of both private insurers and employers to become more prudent buyers of health care. These measures include the substitution of appropriate, less resource-intensive care (ambulatory care in a physician's office) for unnecessary, resource-intensive acute care.

Studies have documented repeatedly that more discriminate utilization often results in cost savings while maintaining, if not enhancing, quality. In many cases, private employees voluntarily select particular coverage plans with the full knowledge that their employers will pass realized savings to them, in the form of increased salaries or fringe benefits. There is no objective reason to presume that poor people, if presented with the same economic incentives and health care choices, would act differently. Consequently, the Department proposes that a portion of the documented savings, if any, which results from the clients' decision to participate in the HEALTH CHOICES program be shared with the clients directly, or retained and invested in programs that help low-income individuals become independent of public assistance and move out of poverty.

This discussion begins with a brief overview of the basic quality and cost inefficiencies inherent in the existing Medicaid program, continues with a discussion of the potential consequences of continued reliance on this system, and concludes with a more detailed review of the proposed alternative Medicaid program structure.

CURRENT MEDICAID DELIVERY SYSTEM

One of the Department's top priorities is to ensure - through the Medicaid program - access to quality, appropriate, cost-effective health care services for the poor. Despite Medicaid's success in generally broadening the availability of medical care coverage for the low-income population (elderly, disabled, and families), both nationwide and in the Commonwealth, there is a developing consensus that the current fee-for-service bias of the Medicaid delivery system effectively thwarts achievement of this basic goal, to the detriment of the health and welfare of poor people.

At present, most Medicaid recipients receive care through the traditional fee-for-service system. Every month, each of the state's more than 260,000 Medicaid cases (434,000 recipients) receives a paper Medicaid identification card. These cards provide recipients with virtually carte blanche access to the state's extraordinary health care system. Using the card, recipients may obtain almost any service in most health care facilities in Massachusetts. Providers then bill the Department for each service the recipients obtain; recipients are not required to make any payment for services. The program's present fee-for-service emphasis, however, does not ensure the provision of high-quality care in a cost-effective fashion.

- o Quality is not assured. Because there is no ironclad guarantee that indigent people will be able to secure the services of a personal physician, the system fails to consistently ensure continuity of care. Indeed, recipients may receive routine treatment from many different practitioners, rather than from a personal physician. Further, the Department does not have a system for monitoring the quality of care delivered.

- o Access to care is not guaranteed. In areas with low Medicaid provider participation rates, the fee-for-service system does not ensure the provision of necessary and appropriate services. Thus, many poor people inappropriately become dependent on acute hospital emergency rooms and outpatient departments for their primary and specialty care.
- o Costs cannot be controlled. The fee-for-service system does not ensure the delivery of appropriate services in a cost-effective fashion. The system pays providers for each service they deliver. As such, it at least implicitly encourages providers to deliver more, and more intensive, services than necessary as a means of increasing their reimbursement.
- o There are no economies of scale. The present system does not confine the purchase of Medicaid services to the most economical providers available, despite wide variations in charges for similar services within some provider groups, particularly hospitals.

Thus, the Department pays for recipient and provider decisions about the use of services but has little influence over those decisions, nor the ability to ensure that recipients receive continuity of care. Of no less concern is the fact that, either because of the inappropriate use of more intensive, higher-cost services or because delays in primary treatment result in unnecessary emergence of acute illness, the current delivery system contributes significantly to a severe misallocation of resources.

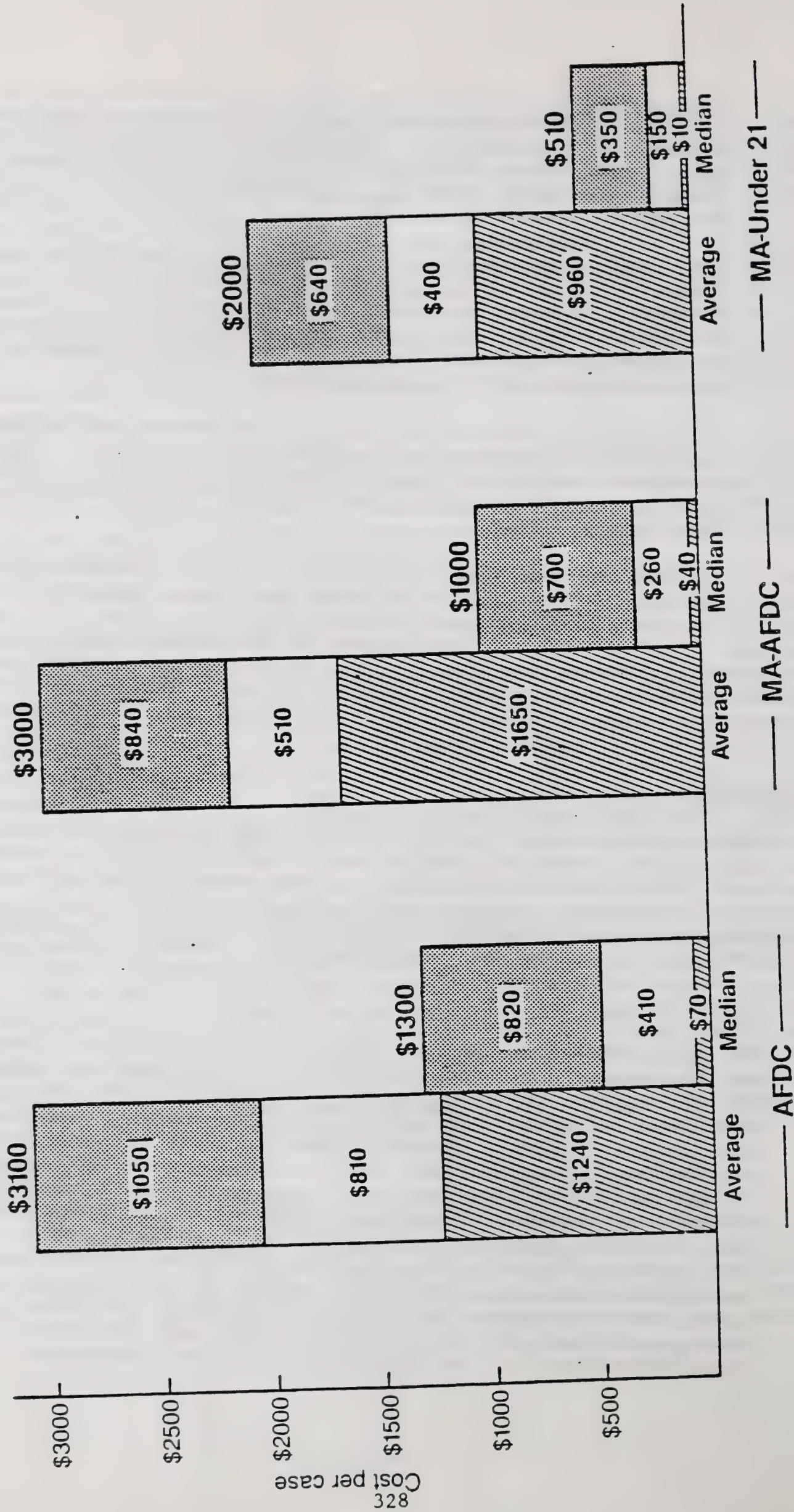
UTILIZATION

Medicaid utilization data -- data which describe the amount and intensity of health care resources used by each Medicaid recipient -- is an important and illustrative indicator of the extent of the misallocation of Medicaid resources within the Medicaid caseload as well as relative to other populations. The text below highlights the major Medicaid utilization data for the AFDC population.

A. Mean v. Median Cost Per Case

The inequitable and, perhaps, inappropriate allocation of Medicaid resources is reflected in a comparison of the average and median cost per AFDC-related case. Average cost per case is a common measure of the usual value of the medical benefits Medicaid families and individuals receive. However, because an average ignores the distribution of expenditures among the caseload and is often skewed by extreme values, it does not necessarily provide an accurate indicator of the "benefits package" provided to the typical Medicaid case. For this reason the median cost per case, because it trims the small number of atypical high-cost cases that skew the average, may be a more appropriate statistical measure of the worth of medical benefits used by typical utilizers. A comparison of the average and median aggregate cost per case indicates that the value of the "benefits package" at the median, or that received by the typical

PROJECTED FY 87 AVERAGE VS. MEDIAN COST PER CASE (FAMILIES) BY PROVIDER TYPE



Provider Types:

- Acute Hospital Inpatient
- Acute Hospital Outpatient
- Other Services

case, is indeed substantially less than the average "benefits package". As shown in the graph on the preceding page, the average annual cost per AFDC case (\$3100) is over twice as high as the median (\$1300). (A similar relationship between the mean and the median cost per case also exists for the other AFDC-related categories of assistance.) These data suggest that a small number of Medicaid recipients in the AFDC, MA-AFDC, and MA-Under 21 populations uses a disproportionately large amount of Medicaid resources.

B. Small Percentage of "High Utilizers"

The rather striking distribution of Medicaid costs within the three AFDC-related categories of assistance suggests that the costs of a small number of recipients skew the average and that the bulk of the caseload utilizes considerably less medical care than the average implies. Evidence of this is found in the fact that approximately 7% of the recipients (individuals) in the AFDC caseload use approximately half of the resources consumed by all AFDC recipients combined. This is somewhat higher than the proportions reported for other populations; about 5% of Medicare-eligibles and 3% of the privately insured use half of the resources consumed by their respective populations.

A comparison of the average and median annual cost per case by provider type provides additional information on Medicaid utilization patterns. As the graph shows, acute hospital inpatient services consume a far more substantial portion of total expenditures in an average AFDC benefit package than they do in a median benefit package. For example, acute hospital inpatient care accounts for 40% (\$1,240) of expenditures in the average AFDC benefit package compared with only 5% (\$70) in the more typical median AFDC benefit package. In terms of actual benefits, this translates to approximately 3.5 hospital days annually for the average case and only slightly over one-tenth of one day for a case at the median.

The AFDC caseload's "highest utilizers" (i.e., top 10% of the cases) generate almost 80% of total inpatient expenditures for AFDC cases. These data provide further evidence that a relatively small number of recipients skews the average cost per case, and that the value of Medicaid benefits received by the "typical" AFDC case is much lower than the average implies.

The Department recognizes that this type of relationship -- a small proportion of recipients using a disproportionate amount of resources -- probably occurs across all payers. However, the comparative utilization data below suggest strongly that this relationship is even more pronounced for the Medicaid population.

C. Medicaid v. Non-Medicaid Population

Based on a Rate Setting Commission study of hospital case mix and billing data in 1983, the table below shows the average acute hospital length of stay by expected payer for the five most prevalent diagnoses for the Medicaid pediatric population. The report indicates that for three of the five diagnoses, Medicaid's average length of stay exceeds all other payers; and for one other diagnosis, Medicaid's average is exceeded only by one payer. Moreover, the Medicaid average length of stay for all pediatric diagnoses is 42%, or more than 1.5 days, higher than the payer with the lowest total average length of stay.

<u>Average Length of Stay (ALOS) by Expected Payer by Pediatric DRG*</u>					
Pediatric Diagnosis	Medicaid	BC/BS	Commercial Insurer	HMO	% By Which Medicaid ALOS Exceeds Payer with Lowest ALOS
Bronchitis & Asthma	4.1	3.6	3.7	3.1	32%
Neonates w/ other significant problems	3.9	3.7	3.6	3.1	26%
Esophagitis & Gastroenteritis	4.0	3.2	3.2	3.2	25%
Normal Newborn	3.4	3.7	3.6	3.1	10%
Simple Pneumonia & Pleurisy	<u>4.9</u>	<u>4.5</u>	<u>4.5</u>	<u>5.0</u>	<u>9%</u>
TOTAL FOR ALL PEDIATRIC DIAGNOSES	5.4	4.5	4.5	3.8	42%

* Pediatric DRGs include children from birth to 17 years of age.

The results of this analysis show that Medicaid recipients' average length of stay for some of the most prevalent Medicaid pediatric diagnoses are noticeably longer than for individuals covered by either private insurance or an HMO. Because total pediatric diagnoses account for over 164,000 Medicaid acute hospital days, these variations have a significant impact on Medicaid expenditures. To the extent that this utilization phenomenon is a direct function of the fee-for-service delivery system (no incentives to promote cost control, and inadequate provision of primary care), rather than inherent to the medical care needs of the AFDC population, the Department believes that continued reliance on the traditional Medicaid fee-for-service delivery system would have several major negative consequences:

- o economic - first, it constitutes an imprudent distribution and inequitable allocation of scarce resources. Stated more bluntly, money is leaking out of the system due to the complete absence of reasonable quality and cost controls. In effect, the cost of providing medical care is inadvertently

draining funds that could be used to meet the needs of poor people more effectively.

- o quality - second, the system does not promote well-managed, primary-preventive health care. Limited access to primary care is reflected directly in an overdependence on acute hospital outpatient department care and emergency room (OPD/ER) care. Many low-income individuals rely on hospital OPDs/ERs for routine care that they could obtain less expensively in a community health center or a doctor's office. A Department study in 1983 indicated that, in the case of some hospital facilities, outpatient department charges can be as much as 500% more than charges for the same service delivered in a community health center or in a freestanding physician's office.

National data show that visits to hospital OPDs/ERs account for 21% of Medicaid recipients' visits to medical providers, while OPD/ER visits account for only 12% of visits by the general population and 11% of visits by the privately insured. Moreover, a recent Presidential Commission report noted that "while 3% of higher-income, urban whites with insurance consider the hospital emergency room or emergency department to be their usual source of care, 36% of poor blacks who lack insurance and live in these areas identify these hospital facilities in this way."

Moreover, the ready availability of primary care fosters illness prevention, and permits early diagnosis and treatment, so that the individual may be spared the consequences of more serious acute and protracted illnesses. Provision of inappropriate services, particularly unwarranted surgical care, is both costly and potentially bad medicine as it unnecessarily places individuals at risk of preventable complications and of iatrogenic diseases contracted in the hospital during recuperation. Because many poor people lack a social support system and are already hard-pressed to simply make ends meet, these episodes, some of which could be prevented through the provision of primary care, may have an even more destabilizing impact on this particularly vulnerable population.

- o social - third, and perhaps most damaging, continued reliance on the traditional fee-for-service system would effectively perpetuate the current dual-care medical system based on socioeconomic status: one system for low-income individuals and a second for those with greater resources. At present, middle- and upper-income people, generally through an employment-related fringe benefit package, can choose health care coverage from among a broad menu of private insurance plans (i.e., Blue Cross; Prudential; Aetna) or alternative plans (i.e., health maintenance organization; and preferred provider organizations).

Indeed, a growing proportion of the non-poor Massachusetts population is choosing to enroll in coordinated health care programs. As shown in the table below, over the first half of 1985, total HMO enrollment of the general population with private insurance increased by about 143,000, or nearly 24%, bringing the aggregate total to nearly 740,000 or 20% of the eligible population. The growing number of HMOs and similar-type health care systems have made coordinated care a realistic option for an increasing number of non-poor citizens in the Commonwealth. Unfortunately, despite the steady increase in Medicaid coordinated health enrollment over the last few years, most poor people still do not have the opportunity to receive care through these providers. Indeed, only 3% of the Medicaid population receives care via a coordinated care provider. Perhaps even more alarming is the likelihood that the coverage gap between poor and non-poor citizens will widen. For instance, as of the end of June 1985, only 7 of the 18 HMOs in Massachusetts participated in the Medicaid program. Medicaid enrollment growth was only 7% over the first half of calendar year 1985, compared with 24% for the general population.

<u>COORDINATED HEALTH ENROLLMENT TRENDS</u> <u>FOR THE MEDICAID AND GENERAL POPULATIONS</u>				
<u>Population</u>	<u>Total Growth</u> <u>January-June</u> <u>1985</u>	<u>% Growth</u> <u>January-June</u> <u>1985</u>	<u>Total</u> <u>Enrollment</u> <u>June 1985</u>	<u>% of</u> <u>Respective</u> <u>Population</u>
MEDICAID	850	7%	13,200	3%
GENERAL POPULATION WITH PRIVATE INSURANCE	143,000	24%	740,000	20%

PROPOSED SOLUTION

Recognizing the serious quality and economic problems associated with the current Medicaid delivery system, the Department believes it is imperative that Medicaid be redesigned to meet the clients' needs more adequately. In developing this proposal, the Department has carefully evaluated the options proposed and executed by other states and by other payers.

Many states have incorporated into their Medicaid programs service limitations and/or cost-sharing requirements. Specifically, over 40 states impose restrictions on major acute and primary health care services, including both limitations on reimbursable hospital days and non-coverage of certain medical procedures. In addition, twenty-two

states require recipients to cost share (i.e., copayments, deductibles) for certain services.

The Department considers these measures unnecessarily regressive because they are indiscriminate in their approach, unjustly placing on recipients the burden of remedying the problem of inappropriate utilization. Because this state remains fully committed to preserving to the maximum extent recipients' freedom of choice, these measures were rejected.

Instead, the proposed HEALTH CHOICES program would allow poor people to avail themselves of the same health care services as people of greater means, through the availability of three health care coverage plans:

- o coordinated health care;
- o private insurance; and
- o revamped fee-for-service Medicaid.

No punitive initiatives are incorporated in any of the plans. The intent is to encourage providers and recipients to voluntarily dispense and consume resources appropriately, through more positive incentives designed to influence behavior. To the extent that efficiencies are realized, savings will be shared among the state, providers and recipients.

The three coverage plans are described in detail below.

COORDINATED HEALTH

A. Program Potential

The Coordinated Health Program would be the first option available to Medicaid families and children under the HEALTH CHOICES Program. The Department's coordinated health program (CHP) is intended to provide continuing, comprehensive, high-quality care to enrolled recipients. Enrollees select a single provider (e.g., community health center, health maintenance organization, or physician) who provides or arranges for all necessary health care services. CHP enrollees are entitled to exactly the same benefits as a fee-for-service user, either through their CHP provider or by utilizing the fee-for-service system for services not included in the CHP package. However, enrollees receive only that care which is deemed necessary by the CHP provider. Such an arrangement guarantees that the recipient has access to necessary services, while also guaranteeing that the Department pays only for appropriate, necessary care. In short, coordinated health offers significant advantages to recipients, particularly:

- o offering individuals and families the opportunity to have their own personal physician on whom they can rely to respond to their health-related questions and to provide routine and coordinated care rather than continuing to receive fragmented care in institutional settings;

- o promoting quality care through the assurance of continuity of services, rather than indiscriminate utilization as fostered by the fee-for-service system, while assuring 24-hour access to necessary care and availability of most services in a single location; and
- o ensuring the continued availability of the comprehensive medical package currently offered by the Commonwealth, through successful expansion of coordinated health, and avoidance of restrictions on services which may eventually occur if the Department fails to act responsibly to control Medicaid costs.

The quality issue merits particular attention. The Department's contracts with coordinated health providers include an extensive set of quality and access requirements. The Department monitors provider compliance with these requirements on an ongoing basis. This monitoring includes patient record reviews, careful analysis of utilization statistics, and discussions with recipients who disenroll from their coordinated health site. In the event that a provider fails to correct quality or access problems, the Department may cancel the contract. Further, coordinated health staff thoroughly review prospective sites for potential quality and access problems before any contract is signed. This attention to quality and access far exceeds that which the Department can offer to recipients receiving care in the fee-for-service system.

The Department's coordinated health plans are designed to encourage providers to render, and recipients to use, health care services more efficiently. Ideally, the Department contracts with health plans to meet the medical needs of the recipients within a target expenditure amount. This target is lower than the average cost of meeting recipients' medical needs in the fee-for-service system, but still gives providers a reasonable return for their services. The health care plans have a particular incentive to meet recipient medical needs cost-effectively because plans that achieve savings for the Department are often eligible for a share of those savings. Plans that fail to achieve savings are often at risk for at least a portion of the resulting overspending. Savings accrue because health plans, given the opportunity to share in the savings, provide care in more cost-effective settings and reduce unnecessary and duplicative care.

Coordinated health providers render cost-effective care by:

- o delivering services, whenever possible, in noninstitutional settings and, when hospital care is necessary, delivering that care in the most cost-effective hospital that will meet the recipient's needs;
- o ordering only those tests and other ancillary services necessary for diagnosis and treatment; and
- o designing economical and, when appropriate, nonmedical follow-up care.

The coordinated health program represents a significant change from the existing fee-for-service system, for both providers and recipients. First, in return for the qualitative benefits of coordinated health, recipients must modify their utilization behavior by agreeing to rely on one provider or plan for their health needs. Second, providers benefit economically from controlling costs; under the fee-for-service system, providers are acting against their own interests to economize, since the less they spend, the less they receive in reimbursement.

In summary, through a variety of mechanisms coordinated health plans have the potential to promote a more judicious use of resources than the fee-for-service system, the structure of which inappropriately encourages and rewards inefficient utilization and delivery of health care services.

B. Current Program Problems

The Department believes that a system of coordinated care is an important alternative for low-income people, not only because it ensures that recipients obtain necessary services in cost-effective settings, but because this health care option today is commonly accepted as mainstream care. Recent trends in HMO enrollment in Massachusetts for the general public -- including moderate- and higher-income families and individuals who generally receive health insurance coverage as a benefit of employment -- indicate that non-poor people are demonstrating an increasing tendency to choose coordinated health care options.

As noted earlier, during the first half of calendar year 1985, HMO enrollment for the total general population in Massachusetts grew by about 24%, representing an increase of about 143,000. Moreover, the aggregate total enrollment of about 740,000 represents an HMO penetration rate of about 20% of the general population with private insurance (excludes Medicare, Medicaid and uninsured populations). The growing number of HMOs (18) and similar health care delivery/payment systems in Massachusetts have made and will continue to make coordinated care a realistic option for an increasing number of residents in the Commonwealth. Indeed, the greater accessibility of HMOs, combined with the fact that enrollment in an HMO generally means lower out-of-pocket expenses for premiums, coinsurance, and deductibles, has encouraged many members of the general population to move away from the traditional fee-for-service delivery system.

By comparison, Medicaid recipients are proportionately underrepresented in coordinated health plans, and recent enrollment trends do not suggest that inroads are being made to close the gap. Specifically, Medicaid coordinated health (HMOs and other case management plans) enrollment growth was only 7% over the first half of calendar year 1985, compared with the nearly 24% rate for the general population. Moreover, compared with the aggregate 20% HMO penetration rate for the general population with private insurance, the aggregate Medicaid coordinated health enrollment rate was 3% as of June, 1985.

The low Medicaid enrollment and growth rates are a function of several factors, some of which are within the Department's control and which will be addressed over the next fiscal year, including:

- o fiscal incentives - at present, the Department does not provide any tangible incentive, such as cash, for recipients who enroll in these programs. Therefore, despite the important quality-promoting features of the coordinated health, it is not surprising that recipients would have some initial reluctance to enrolling in these programs. Stated simply, since Medicaid recipients already have access to virtually all medical services, recipients often perceive little immediate "economic gain" associated with transfer to a vastly different style of medical care, one which places additional structure on the individual's health care consumption.
- o marketing - given the substantial reorientation of medical care service delivery under coordinated health, it is particularly important that the potential benefits be articulated clearly to the recipient. The Department's marketing efforts need to be improved in order to better execute this task.
- o contracts - some current contracts are open-ended; they contain no incentive clauses or performance-based criteria to promote marketing by the provider or plan.
- o access - in some areas of the state where there are large concentrations of Medicaid recipients, there are no easily accessible coordinated care plans or existing plans which have the ability to expand. Medicaid recipients in these areas of the state do not have a choice among health care options. The Department must identify these communities and work with providers to:
 - stimulate the development of new health care delivery systems capable of providing coordinated, prepaid health care; and
 - integrate Medicaid recipients into these developing care systems.

In order to realize the quality and cost benefits inherent in coordinated health care delivery systems, the Department must pursue aggressively initiatives (discussed below) to increase both recipient and provider participation in coordinated health care.

C. Key Components to Increase Provider and Recipient Participation

- o Provide recipients with financial incentives to enroll in coordinated health. Foremost, the Department will devise a plan to share program savings with recipients. For instance, if the Department saves \$40 per case per month, 50% or \$20 could be returned to the family. The value of providing a cash incentive to encourage enrollment in a coordinated care program has been documented by the Department's primary care case management program.
- o Continue to refine and aggressively apply the marketing plan, including: (i) under a federally-approved waiver the Department will provide guaranteed six-month Medicaid eligibility for individuals who enroll in coordinated health; (ii) a media campaign to promote greater general awareness of the value of coordinated health care; (iii) regional enrollment campaigns at targeted sites; and (iv) additional recipient and provider incentives.
- o Actively recruit HMOs. The Department intends to work with other state agencies to develop administrative incentives to increase participation of existing HMOs in coordinated health. The Department will emphasize measures that promote voluntary participation. However, the Department will consider establishing a regulatory/legislative requirement that HMOs which hold group insurance contracts for coverage of state employees become Medicaid providers if voluntary measures are not successful. In FY85, eight of eighteen HMOs participated in the program; twelve are expected to participate in FY86; and the goal is full participation in FY87.
- o Promote the development of new health care delivery systems. Like HMOs, these providers can render coordinated health care on a prepaid basis. Specifically, the Department will work with physician groups, health centers, and private physicians in targeted communities to form new health care delivery systems which can move toward and eventually assume full risk in prepaid arrangements. The Department will concentrate on:
 - linking existing providers into state-of-the-art health care delivery systems in Massachusetts whereby physicians and hospitals join to form Preferred Provider Organizations (PPOs), Independent Practice Associations (IPAs) and Competitive Medical Plan (CMPs). CMPs, the most recent development in health care delivery systems, were defined by the federal government in order to encourage growth in both the number of provider organizations which contract with Medicare on a prepaid basis and the number of Medicare

recipients enrolled in coordinated health care plans. Since CMPs will serve other populations in addition to Medicare-eligibles, the development of these types of organizations should result in an expanded pool of provider organizations with which Medicaid can contract. Given the administrative complexity of converting existing provider billing and delivery systems to a coordinated health program, the Department is requesting \$1 million in the Medicaid Management account (4400-1003) to fund initiatives designed to increase the availability of coordinated primary health care services. The Department would award a set of grants to providers, primarily in areas with both a high concentration of Medicaid recipients and a shortage of physicians, who agree to manage health services for Medicaid recipients. The grants would provide financial support to enable providers:

- to defray the significant administrative start-up costs of a new program (i.e., data processing, market analysis, 24-hour coverage);
 - to increase capacity and enrollment in existing programs, and to develop additional support services such as bilingual service and nursing coverage; and
 - to develop health screening programs for Medicaid recipients, programs designed to identify chronic or recurring health problems and to encourage ongoing treatment and prevention.
 - to integrate Medicaid recipients into existing coordinated health care delivery systems.
- o Negotiate performance-based contracts with providers. Under such contracts, providers would be rewarded financially for exceeding enrollment targets agreed upon by the provider and the Department.
 - o Expand health care expertise in local welfare offices. In FY87 the Department will broaden the training of local office staff to enable them to provide a wide range of information to Medicaid recipients about health care choices and resources.
 - o Improve operational management of the program. In an effort to attract and retain providers, the Department will offer increased technical assistance and outreach activities, including:
 - (i) implementation of the solo practitioner model, which allows the participation in the coordinated health system of individual physicians and other primary care providers who were administratively unable to participate through other models; and
 - (ii) automation of the patient referral system.

PRIVATE INSURANCE PROGRAM

The private insurance package would be the second health insurance option for Medicaid families and children under the HEALTH CHOICES program. The state would pay a negotiated monthly premium, as corporate clients do, to provide coverage for the package of services typically offered by a private carrier such as Blue Cross/Master Health Plus or PruCare. Services outside of this standard package, which Basic Medicaid and Coordinated Health Programs presently cover, would either be negotiated into the private insurance Medicaid package or reimbursed outside of that plan. Any private plan offered as a part of HEALTH CHOICES would need to be consistent with the primary goal of the Medicaid program: to ensure that health care services provided are medically necessary, of high quality and rendered in the most appropriate health care setting.

In developing the private insurance plan, the Department will devote particular attention to ensuring that all of the following features are incorporated:

- o a full range of health care benefits;
- o quality control;
- o an emphasis on primary care; and
- o no direct cost to the recipient.

Only two other states provide private insurance plan coverage for Medicaid recipients. However, each program mandates participation for every Medicaid recipient. In contrast, a Medicaid purchase of a private insurance plan, as conceived under CHOICES, -- where client participation is optional -- is quite progressive. The important benefits associated with the private insurance plan include potentially increased access to health services for low-income people. Additionally, by creating a progressive "public/private partnership" in the health insurance industry, the state will be able to take advantage of the private sector's knowledge of and experience in health care, particularly efforts to constrain premium costs. Like the other two proposed program options, a portion of the potential savings resulting from implementation of this plan would be shared with recipients directly.

The potential advantages of the private insurance choice effectively address some of the key problems with the fee-for-service Medicaid program and the resultant inequities experienced by recipients. These advantages include the following:

- o Access - a private insurance plan could make non-Medicaid participating providers available to Medicaid recipients and therefore increase the pool of physicians and other providers from whom recipients can obtain care.
- o Payer-Blindness - to the extent that certain providers harbor resentment against government-insured patients, the identification card recipients enrolled in private insurance plans present to providers should serve to alter this situation. Providing increased access to high-quality, cost-effective health

care services will be a major step towards eradicating the dual-class health care system.

- o Built-in Utilization Control Measures - the private plans to be considered would offer state-of-the-art utilization review components such as preadmission screening, second surgical opinion, and concurrent review. This is consistent with the design of the other two components of HEALTH CHOICES, which emphasize the provision of appropriate health care services delivered in the least intensive possible setting.
- o Private Sector Expertise - the proposed partnership would afford the Department greater exposure to innovative utilization control, quality assurance, and other benefit design approaches developed by the private insurance industry to control the rate of premium growth. For instance, the Department could utilize the expertise of private insurers to develop preferred provider and/or selective contracting initiatives. Both of these options encourage the use of cost-effective providers, through special reimbursement incentives. Under these options, a large enough number of providers would be included in these groups to ensure geographic coverage and recipient choice.

BASIC MEDICAID

In addition to the coordinated health and private insurance program options, a revamped fee-for-service program would round out the complement of options to be offered to Medicaid families and children. Under this system, recipients would continue to have access to a comprehensive package of benefits, but the Department would play a greater role in ensuring that services are necessary and provided in a cost-effective manner.

Currently, health care services for the AFDC-related population alone represent over \$300 million in Department spending, of which virtually the entire amount is spent through the traditional fee-for-service system. While the Department is not the largest payer for primary and hospital services in the health care system, the Department has an obligation to both recipients and taxpayers to ensure that the qualitative and economic return on this investment is as substantial and as equitable as possible. To date, however, the Department has not acted as a prudent buyer by exercising the purchasing power this investment should provide. With the underlying assumption that maintaining generous benefits and acting as prudent buyers are by no means mutually exclusive activities, the Department plans to direct significant effort as part of all CHOICES options towards utilization control through provider and recipient education.

As has been noted, the current fee-for-service system has many inherent deficiencies. In an effort to ensure quality and to control health care costs, private payers, business, government, and health care planners have devoted significant attention over the past ten years to utilization issues generated by the fee-for-service system, particularly the

necessity and appropriateness of services delivered. Most major health care payers have adopted a variety of measures designed to assure high quality as well as cost-effective health care. For instance, Medicare has issued a list of several hundred procedures which are considered appropriate to be performed in an outpatient setting and therefore require prior approval from the designated professional review organization in order to be eligible for reimbursement on an inpatient basis. Private insurance carriers, largely driven by the incentive to remain competitive by holding down the premiums paid by the business community, have likewise adopted quality and utilization control measures such as, preadmission screening, second-opinion programs, concurrent review, and case management of high-cost hospital cases.

The Department has also developed and implemented several programs aimed at ensuring appropriate utilization of services, consistent with accepted medical practice. However, despite early efforts to implement effective yet reasonable strategies to control unnecessary utilization, Massachusetts Medicaid has fallen behind vis-a-vis the medical evaluation protocols adopted by other major payers. In essence, the Department's current utilization review system is retrospective; that is, it measures the appropriateness and necessity of a service after it has been provided. Although such a mechanism may be an effective monitoring tool, it has serious deficiencies with respect to promoting more judicious use of resources. This type of utilization review simply justifies the procedure in absolute terms; it makes no provision for relative determinations of appropriateness. Such a utilization review program would approve payment for a service provided in an acute hospital facility without even considering the utility of providing this service in a less costly and potentially more accessible setting, such as an ambulatory care center. The Department must shift its focus to prospective utilization control measures to manage the Medicaid program more effectively.

A. Planned Utilization Control Activities

In order to control utilization prospectively, the provider community must be educated more fully on the possibilities of alternative treatment patterns as practiced by their peers. The intent of these efforts is to entrust ultimate medical care and treatment decisions to the practitioner and patient. Primary activities associated with this effort could include acute hospital preadmission screening and small area-analysis:

- o Preadmission Screening - the Department is currently considering establishing acute hospital preadmission screening for all elective, non-maternity acute hospital inpatient admissions of recipients who are not enrolled in the coordinated health program or private insurance plan options. Consistent with programs implemented by the private sector, the Department would use established and generally accepted medical care criteria. Reviews would consist of a telephone discussion between the admitting physician and a qualified, trained registered nurse employed by the contractor. For authorized admissions, agreed length of stay and pre-operative

day standards will be monitored. Providers would have an opportunity to appeal denied stays to a staff physician reviewer.

Comparable programs have been instituted by a number of states including Kentucky, Michigan, California, and Minnesota. Additionally, Blue Cross (through Master Health Plus) and other private insurers have added pre-admission screening protocols to their insurance plans.

Based on the experience of other states, the Department expects that implementation of the preadmission screening program would result in a significant decrease in acute hospital inpatient admissions and unnecessary surgery, due to the following:

- Shift in emphasis to other health care settings (such as physicians' offices and community health centers) when appropriate.
 - Decrease in length of stay by reducing or eliminating unnecessary pre-operative and post-operative acute hospital days.
 - Through the sentinel effect, reduction in the number of discretionary procedures performed; having to justify every hospitalization encourages physicians to evaluate marginal cases more carefully.
- o Small-area Analysis - patterned on small-area analysis (pioneered by researchers at Dartmouth College and Harvard University), the Department will use utilization reports generated by the Medicaid Management Information System (MMIS) and outside databases to identify atypical treatment and practice patterns for comparable diagnoses. Relevant professional organizations and key individual providers will be issued a series of analyses as an educational tool to initiate appropriate changes in practice patterns. These analyses will also be used to support changes in Medicaid administrative and reimbursement regulations in order to promote more discriminate utilization. Analysis will be concentrated in the following service areas;
- acute hospital inpatient and outpatient
 - nursing home
 - physician
 - pharmacy
 - dental
- o Case Management of High Cost Admissions - selected high-cost diagnoses, such as psychiatric, may be case managed to reinforce efforts at assuring cost-effective care, appropriate lengths of stay, and access to community-based care.

- o Expanding the Second-opinion Program - the Department will continue and strengthen its successful program requiring consultation of a second qualified specialist prior to the performance of certain elective surgical procedures.
- o Restrict certain procedures to the least costly setting(s) - consistent with reimbursement policies of other health care payers, the Department may require that certain medical procedures be provided in an ambulatory setting (i.e., physician's office, acute hospital outpatient department, or health center) rather than in an acute hospital inpatient unit.

B. Summary

Although the provider community might view these activities by private and public institutions as an unwarranted usurpation of its professional authority, basic economic realities suggest that third-party payers are likely, over the next few years, to develop even more aggressive initiatives to control utilization. Savings that may be recognized from the achievement of these goals will be shared with recipients directly. The unacceptable alternative is for the Department to remain idle in the face of ballooning health care expenditures, an inertia which could eventually jeopardize the state's ability to fund the current comprehensive Medicaid health services package.

CONCLUSION

Any new program, particularly an innovative one such as this, will require a large degree of cooperation from many different groups to ensure that the program design incorporates mutually agreed-upon goals and that implementation is successful. Specifically, the support and cooperation of the health care providers and insurance companies, as discussed earlier, is important; the advocacy community will also be critical in providing advice, and, if possible, support. As a program designed to increase access and quality of care, HEALTH CHOICES should elicit a favorable response from advocates. Finally, internal efforts will be required in the areas of actuarial and cost analysis of the private insurance program, as well as marketing the new CHOICES program to AFDC recipients.

MEDICAL ASSISTANCE - MENTAL HEALTH (4402-5300)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures/ Appropriations	28,511,000	37,978,000	44,834,033*	53,149,653

INTRODUCTION

The Medicaid-Mental Health (MA-MH) account was established in FY80 to enable the Department of Public Welfare to fund the Department of Mental Health's (DMH) development of new community programs for many of the Commonwealth's mentally retarded and mentally ill citizens. These new programs are partly the result of the consent decrees negotiated in the 1970s. In FY87, the account will fund six community-based mental retardation and mental health services:

- o intermediate care facilities for the mentally retarded (ICFs/MR)
- o day habilitation
- o early intervention
- o mental health centers
- o psychiatric hospital outpatient departments
- o psychiatric day treatment.

Monitoring expenditures for community mental health and mental retardation services through an account separate from the Medical Assistance account (4402-5000) is particularly important in view of the rapid expenditure growth in the MA-MH account in recent years. Since the MA-MH account was established in FY80, the cost of providing these services has increased an average of almost 33% each year, from \$9.4 million in FY80 to about \$38 million in FY85. As such, it is the fastest growing component of the Medicaid budget. Factors contributing to this growth, described in detail below, include inflation, program growth primarily attributable to the consent decrees, and increased utilization of services.

The H.1. request of \$53.1 million reflects a continuation of this trend of significant annual expenditure growth. Further, services funded through this account represent only a very modest portion of the total amount spent by the Commonwealth to fund mental health and mental retardation services for Medicaid recipients. Additional Medicaid-reimbursable mental health and mental retardation services, totalling approximately \$315 million, are funded through a variety of other budgetary sources. Within the Department's account structure, the Medical Assistance account funds approximately \$35 million in mental health services. The Department of Mental Health funds a number of

* Projected

Medicaid-reimbursable services at an estimated cost of \$280 million which, through the Welfare Department's Finance Division, generates approximately \$140 million annually in federal revenue.

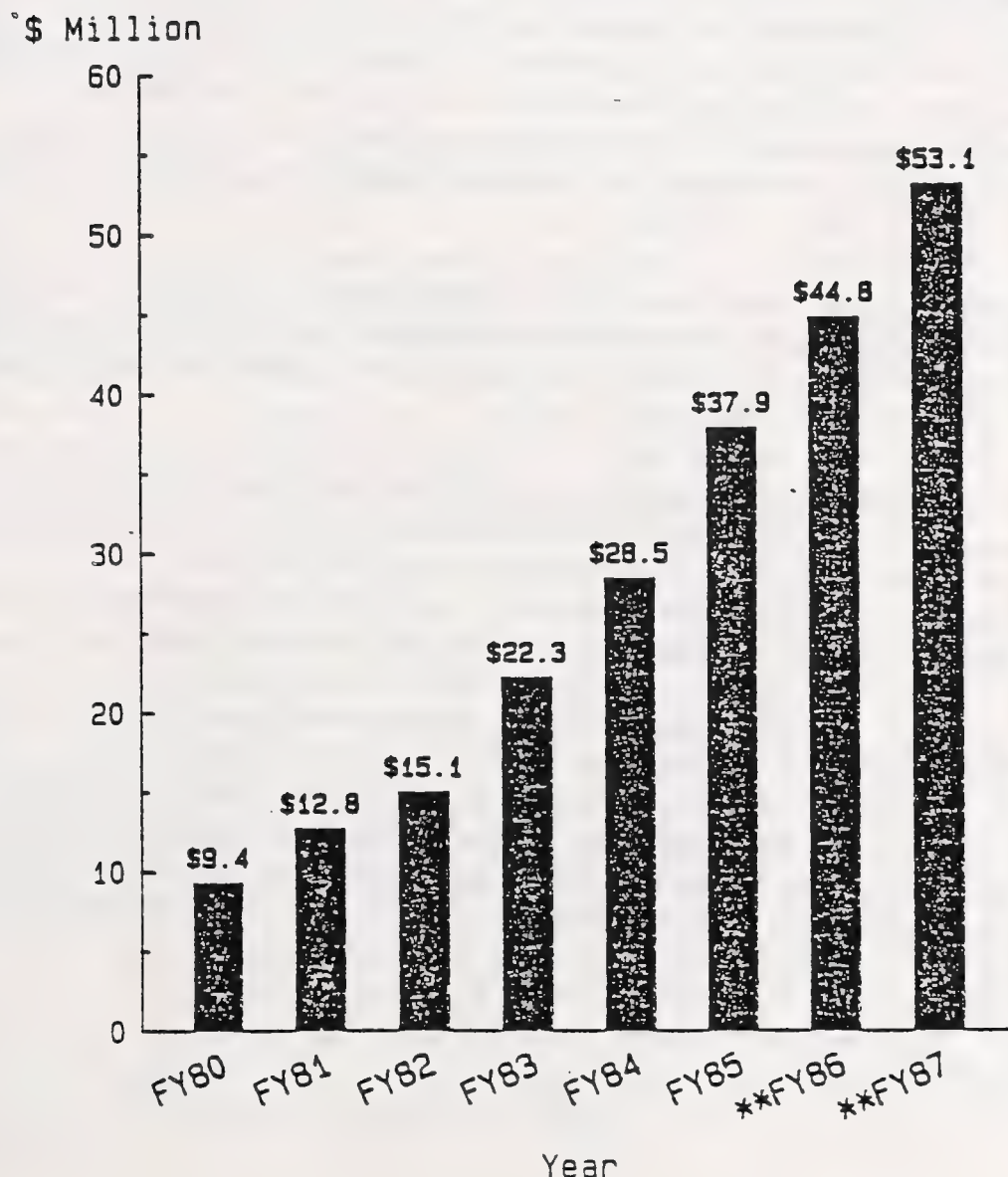
Department of Public Welfare - Medical Assistance Account

- o inpatient psychiatric services in acute hospitals
- o outpatient psychiatric services in acute hospitals
- o inpatient psychiatric services for recipients under 21 in private psychiatric hospitals

Department of Mental Health - Medicaid-reimbursable Services

- o state schools for the mentally-retarded
- o state hospitals for the mentally ill
- o home-and-community based waiver for the mentally-retarded

**MEDICAID-MENTAL HEALTH
EXPENDITURE GROWTH*
(FY80-FY87)**



*Fastest growing part of Medicaid budget
**Projected

MEDICAID-MENTAL HEALTH: 1983-1986

Over the past several years the Department, in cooperation with the legislature and the Department of Mental Health, has made several notable improvements in the area of community-based mental health and mental retardation services. Many of these have been in fiscal and/or programmatic support of the Commonwealth's deinstitutionalization efforts; others are designed to increase recipient access to services. Some of the most important initiatives in the area of Medicaid-Mental Health services are described below:

- o Home- and Community-Based Services Waiver - This program provides federal Medicaid-reimbursement (a projected \$35M in federal money over the three-year waiver period) for seven community-based services provided to 900 mentally retarded recipients. Medicaid reimbursement for services such as respite care, transportation, and residential and day programs supports deinstitutionalized clients in less restrictive community settings and also provides federal revenue for the Commonwealth.
- o Community Programs for the Mentally Retarded - By the end of FY87 the Department will have certified over 24 new intermediate-care facilities for the mentally retarded (almost tripling the number operational in FY83) and a projected 17 day habilitation programs. These community facilities represent a major component of the Commonwealth's successful deinstitutionalization activities, enabling hundreds of clients to permanently leave the state schools.
- o Early Intervention - This new Medicaid benefit provides comprehensive prevention services to infants and children under the age of 3 years old who are at risk of developing disabling conditions.
- o Inpatient Psychiatric Services for Children under 21 - This new benefit increases emotionally troubled children's access to inpatient care in private psychiatric hospitals and also provides federal revenue to the Commonwealth for similar services provided in facilities operated by the Department of Mental Health.
- o Increased Revenue - The Department has worked with other state agencies in the development and implementation of revenue initiatives in many program areas, including mental health and mental retardation. The under 21 inpatient psychiatric benefit and the home-and community-based waiver program provides federal Medicaid reimbursement for services which were previously fully state-funded.

CONSENT DECREES AND THE MA-MH ACCOUNT

The Department of Mental Health's current deinstitutionalization efforts were accelerated by a series of class action suits filed in the 1970s on behalf of individuals residing in the five state schools for the mentally retarded and in one state hospital for the mentally ill. The suits did not go to trial because the state negotiated a series of agreements with the plaintiffs. The agreements included plans to improve conditions in the state facilities and to move many residents of the institutions into community-based facilities. These agreements, signed by all the parties involved, became consent decrees establishing a legally binding requirement for the state to upgrade existing facilities and to develop new community-based programs. In addition, the decrees require the Commonwealth to develop an individual service plan (ISP), which serves as a treatment plan, for each member of the plaintiff class; and to update the ISP yearly. The class includes the residents in each facility at the time of the suit concerning it, and any individual who has resided in one of the affected facilities for more than 30 consecutive days since the filing of the suits.

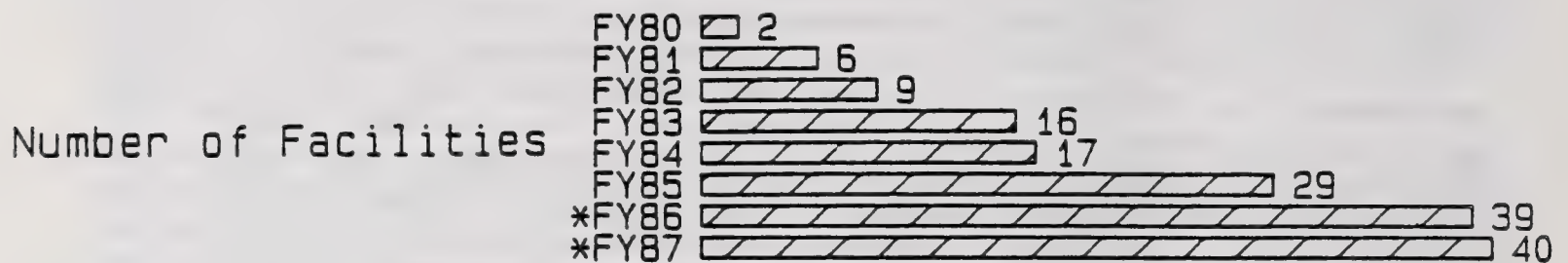
As a result of the consent decrees and deinstitutionalization efforts, the state school population has declined from over 6,000 at the time of the decrees to its present level of approximately 3,600. Some of these clients currently reside in community ICFs/MR. Further reductions in the population are planned to take place through 1987, with additional clients moving into newly constructed community ICFs/MR.

Another result of the deinstitutionalization movement is the even more dramatic decline in the number of patients in the state psychiatric hospitals--from almost 12,000 in 1960 to about 2,000 as of September 1985. Community-based programs such as Medicaid-reimbursable mental health center and psychiatric day treatment services described later in this section have been developed to support people living in the community in becoming more self-sufficient. There remains, however, a fundamental philosophical debate between proponents of community and institutional services. The factions argue about the value of treatment provided in institutional and community settings and disagree over funding levels allocated to each.

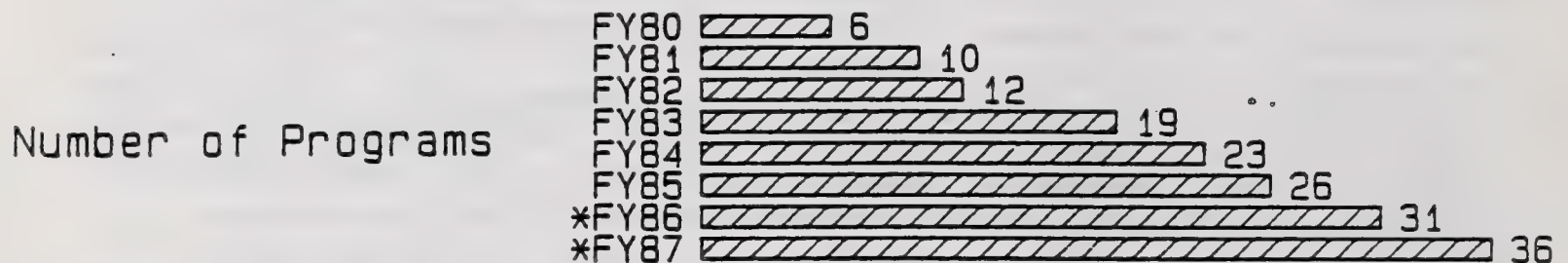
To further direct energy towards evaluating and meeting the needs of chronically mentally ill persons, the Executive Office of Human Services (EOHS) established the Mental Health Action Project in December, 1984. The project brought together people with many different views on mental health services in an effort to produce recommendations for action in this area. The Committee's final report, released in early FY86, and the Governor's special message on mental health which followed, request funding for the following improvements in services for chronically mentally ill citizens: (1) comprehensive emergency and support services such as crisis intervention and case management; (2) improvements in the quality of inpatient care delivered in state facilities; (3) new community housing units; and (4) basic management improvements. EOHS also estimates \$10.5 million through FY91 in new Medicaid revenue as a result of upgrading inpatient facilities to meet federal certification standards.

MEDICAID-MENTAL HEALTH PROGRAM EXPANSION (FY80-FY87)

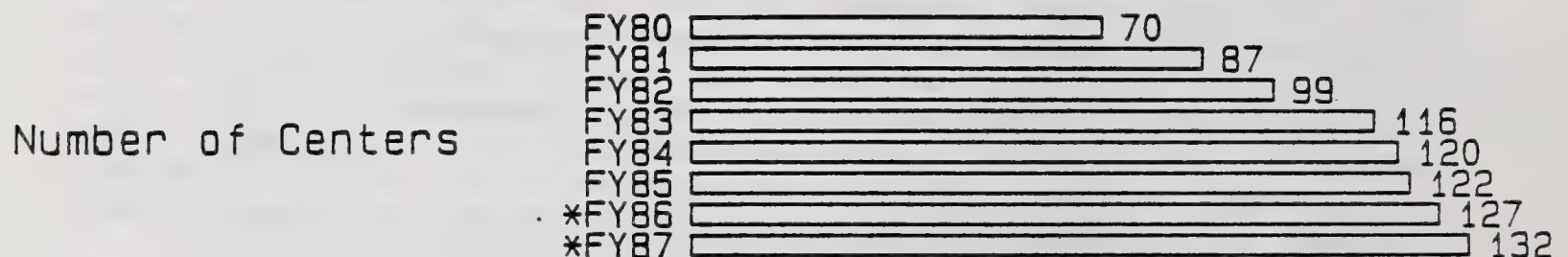
ICF/MR



Day Habilitation



Mental Health Centers



Psychiatric Day Treatment



Note: Represents cumulative total number of
programs each year

*Projected

PROGRAMS FUNDED THROUGH THE MA-MENTAL HEALTH ACCOUNT

As noted earlier, the MA-MH account will fund six community-based programs in FY87. These include three programs for mentally retarded recipients (ICFs/MR, day habilitation, and early intervention) and three programs for recipients with mental illness (mental health center, psychiatric hospital outpatient department, and psychiatric day treatment). Following are descriptions of these six programs.

A. Community-Based Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Community-based intermediate care facilities for the mentally retarded (ICFs/MR) are residential facilities, containing between five and twelve beds (though most contain eight), that provide room and board and a planned program of care and supervision to developmentally disabled persons on a continuous, 24-hour basis. ICFs/MR also provide or arrange for active treatment for their residents. Before entering an ICF/MR each resident must receive a comprehensive initial evaluation that documents his/her functional level. This evaluation must include a review of the need for the care and services in the ICF/MR and a recommendation for ICF/MR placement. The active treatment that residents receive may include: physical and occupational therapy; speech/language pathology and audiology; medical services; and psychological, recreational, social, and rehabilitative services. The active treatment services of an ICF/MR may be provided either at the facility or at another location in the community. Most residents leave the ICF/MR during the day to attend programs, such as the day habilitation programs described below, in which they receive a major portion of their active treatment. This active treatment is designed to improve residents' level of functioning so that they may move from the ICF/MR to a less restrictive environment.

Two types of community-based ICFs/MR are reimbursable under the Medicaid program:

- o Type A facilities serve persons who are incapable of "self-preservation," which is defined by federal regulation as the ability to evacuate a building in an emergency within a reasonable amount of time. These persons receive intensive and continuous care.
- o Type B facilities generally serve less severely disabled persons.

The Department pays a per diem rate, established by the Rate Setting Commission, which covers the cost of most services provided to residents. In FY85, the average per diem rate was \$143 for Type A facilities and \$111 for Type B facilities. Based on these average rates, the annual cost of a Medicaid recipient's care for one year is \$52,200 in a Type A facility and \$40,500 in a Type B facility. This does not include the cost of the active treatment component provided

by day habilitation programs, which may be as much as \$12,000 per recipient per year. These high rates result in part from the high staff-to-patient ratio required by the federal regulations governing ICFs/MR and day habilitation programs. In addition to the per diem and day habilitation costs, ICF/MR residents receive a number of other Medicaid-reimbursable health care services funded through the Medical Assistance (4402-5000) account.

Expenditures for ICF/MR services were approximately \$7.8 million in FY85. In FY87, the Department requests \$14.8 million due to expansion of the ICF/MR program which is occurring in FY86 and that which is requested for FY87.

<u>ICF/MR Program and Expenditure Growth</u>								
	<u>FY80</u>	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>	<u>FY84</u>	<u>FY85</u>	<u>FY86*</u>	<u>FY87*</u>
Type A	2	2	3	4	5	13	23	24
Type B	0	4	6	12	12	16	16	16
Total Facil.	2	6	9	16	17	29	39	40
Total Beds	16	52	76	132	140	229	307	315
Expenditures \$.3M	\$1.1M	\$2.2M	\$3.3M	\$5.1M	\$7.8M	\$12.0M	\$14.8M	
* Projected								

B. Day Habilitation Programs

Day habilitation programs serve mentally retarded and developmentally disabled adults living in community settings whose intensive therapeutic needs are not appropriately met by mental health center or acute hospital outpatient department services. The programs provide a wide range of services designed to support these individuals in living more independently. Services include:

- o developmental training;
- o physical, occupational, and speech/language therapy;
- o medical, nursing, and social work services; and
- o psychological/behavioral services.

Approximately 800 Medicaid recipients are served by day habilitation programs each month. At an average per diem cost in FY85 of \$43, the average annual cost per full-time recipient (five days per week, 50 weeks per year) is \$10,750. Some recipients in day habilitation programs also receive ICF/MR services.

As of December 1985, 26 day habilitation programs participated in the Medicaid program. All of these are freestanding facilities. To become eligible for Medicaid reimbursement, day habilitation providers must be certified by the Department. In FY86, five

additional programs are expected to be certified; in FY87 another five programs are projected, bringing the total to 36.

In FY85, the Department spent \$6.4 million for day habilitation services. Projected FY87 expenditures are \$10.8 million.

Day Habilitation Program and Expenditure Growth

	<u>FY80</u>	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>	<u>FY84</u>	<u>FY85</u>	<u>FY86*</u>	<u>FY87*</u>
Programs	6	10	12	19	23	26	31	36
Expenditures	\$.9M	\$ 1.2M	\$ 2.2M	\$ 3.3M	\$ 3.8M	\$ 6.4M	\$ 7.5M	\$ 10.8M

*Projected

C. Early Intervention

Early intervention programs provide multidisciplinary and coordinated health services to children aged three years or younger who are handicapped or are considered to be at serious risk of becoming handicapped due to biological or environmental factors. The program focuses on three different groups of children: those who are "established risks," for example, children with Down's syndrome, cerebral palsy, or spina bifida; those who are "biologically at risk," for example, children with low birth weights; and those who are "environmentally at risk," because although biologically healthy, the opportunity for physical and/or social stimulation is limited by their family or home situation such that their development may be delayed. Early intervention programs provide treatment and therapy from nurses, social workers, therapists, and educators to reduce potential disabilities and to assist children and families in coping with medical and developmental conditions that cannot be improved.

Early intervention services are a combination of medical and social services, but only the medical portion is reimbursable under the Medicaid program. During FY84 and FY85 the Department worked closely with the Department of Public Health and the Rate Setting Commission to develop this new Medicaid benefit. Implementation of the program occurred during the second half of FY85. Now that the program has been successfully developed and implemented, the Welfare Department expects to spend approximately \$1.5 million on early intervention services in FY87.

D. Mental Health Centers

Mental health centers provide comprehensive diagnostic and treatment services to mentally/emotionally troubled or disabled persons and their families. Among the individuals served are former patients of state psychiatric hospitals, but many recipients of mental health center services have never been hospitalized. Clinic services are

provided by an interdisciplinary team of psychologists, psychiatric nurses, social workers, counselors, and occupational therapists. Mental health center services funded through the MA-MH account are provided by freestanding mental health centers and community health centers. Mental health center services provided in acute hospital outpatient departments and hospital-licensed health centers are funded through the Medical Assistance account (4402-5000). Psychiatric hospital outpatient departments also provide mental health center services. Projected expenditures for services provided in this setting, previously included in the mental health center projection, are now calculated and itemized separately. A description of psychiatric hospital outpatient services appears on the next page.

As of December 1985, there were 122 freestanding mental health centers certified to participate in the Medicaid program. In order to become certified, providers must first receive a Determination of Need approval, which enables them to be licensed by the Department of Public Health. Providers must then be certified by the Welfare Department. In FY86, the Department expects five new centers to become eligible to participate in the Medicaid program with five additional centers anticipated in FY87.

In FY85, the Department spent approximately \$18.2 million for mental health center services. Total FY87 expenditures are projected at \$20.4 million.

Mental Health Center Program and Expenditure Growth

	<u>FY80</u>	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>	<u>FY84</u>	<u>FY85</u>	<u>FY86*</u>	<u>FY87*</u>
Centers	70	87	99	116	120	122	127	132
Expenditures	\$7.5M	\$8.9M	\$9.6M	\$14.5M	\$15.4M	\$18.2M	\$18.7M	\$20.4M

*Projected

E. Psychiatric Hospital Outpatient Departments

Ambulatory mental health services are also provided in psychiatric hospital settings. There are currently seven providers in this group: McLean Hospital and the six locations of Human Resource Institute. These are private facilities whose primary function is providing psychiatric care. Similar care provided in public psychiatric hospitals is funded by the Department of Mental Health.

The Department expects to spend \$2.8 million for psychiatric hospital outpatient services in FY87. No expansion of the provider group is anticipated in FY86 or FY87.

F. Psychiatric Day Treatment

Psychiatric day treatment programs serve persons with mental illnesses who need more active, intensive treatment than is typically available through mental health centers or psychiatric/acute hospital outpatient departments in order to divert those patients from full-time hospitalization or institutionalization. Such persons may be in transition from hospital to community living, or may have had no previous hospitalization. Psychiatric day treatment programs provide therapeutic and rehabilitative services, such as individual or small-group therapy and vocational counseling, in sessions of varying length: full day, half day, and quarter day. Attendance at psychiatric day treatment sessions varies according to the needs of the patient. Some receive short-term, intensive psychiatric day treatment, attending full-day sessions five days a week for a limited period of time, usually not more than four months. Others attend psychiatric day treatment sessions once a week for a period of years to treat recurring and long-term psychiatric illness.

Psychiatric day treatment services may be provided by freestanding centers or by hospital-based mental health centers. To become certified to participate in the Medicaid program, providers must be licensed by the Department of Public Health and certified by the Welfare Department. As of December 1985, 30 psychiatric day treatment centers were certified to participate in the Medicaid program; 4 of these are freestanding and 26 are based at mental health centers. In FY86 and FY87 the Department expects that three new psychiatric day treatment centers will be certified, bringing the total number of centers to 33 by the end of FY87.

In FY85, the Department spent approximately \$2.4 million for psychiatric day treatment services. Each fully operational center with an FY86 daily rate per client of \$43.31 represents an average cost to the Department of \$80,000 per year. Spending for these services is projected at \$2.5 million in FY86 and \$2.9 million in FY87 as a result of the expansion in the number of programs and rate increases during these fiscal years.

Psychiatric Day Treatment Program and Expenditure Growth

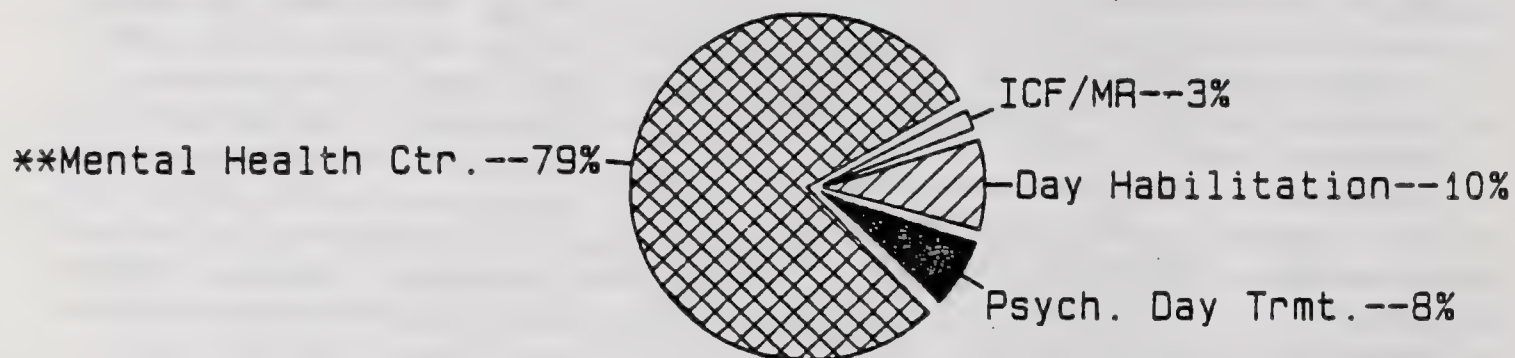
	<u>FY80</u>	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>	<u>FY84</u>	<u>FY85</u>	<u>FY86*</u>	<u>FY87*</u>
Programs	10	5	20	27	28	30	32	33
Expenditures	\$.7M	\$.3M	\$1.0M	\$1.2M	\$1.6M	\$2.4M	\$2.5M	\$2.9M

*Projected

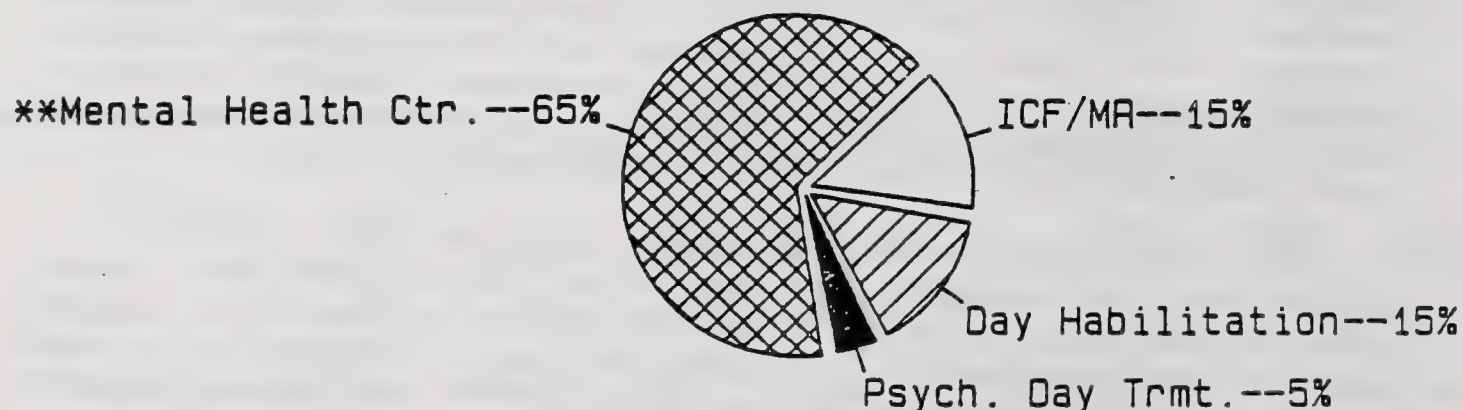
The next section describes in detail the factors contributing to the rapid growth of MA-MH expenditures in recent years.

DISTRIBUTION OF MEDICAID-MENTAL HEALTH EXPENDITURES BY PROVIDER TYPE (FY80, FY83, FY87*)

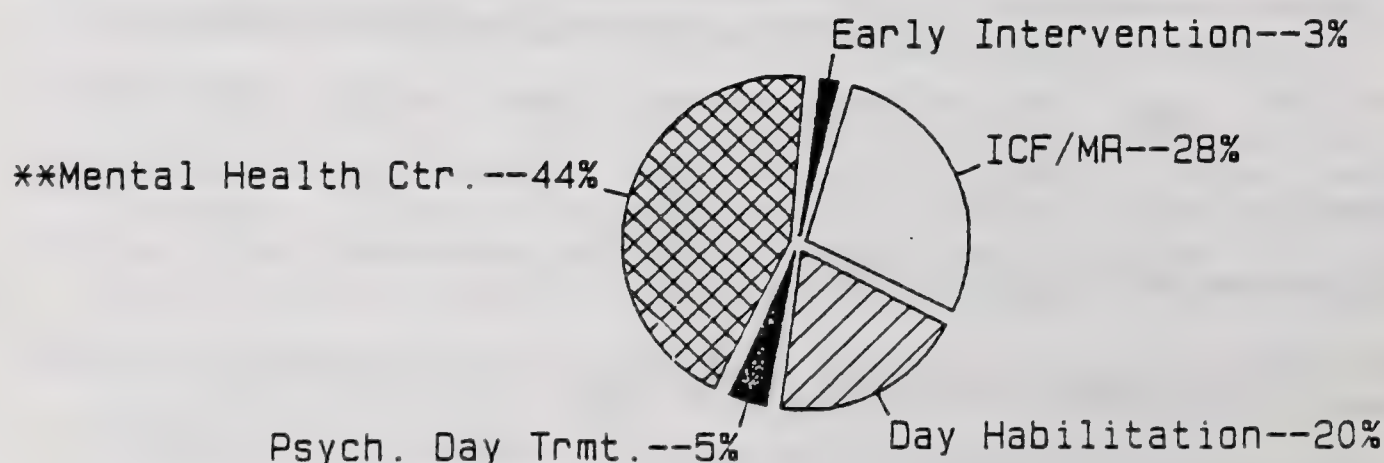
FY80 (Total = \$9.4 million)



FY83 (Total = \$22.3 million)



FY87 (Total = \$53.1 million)



*Projected

**Includes Psychiatric Hospital
Outpatient Services

EXPENDITURE AND PROGRAM GROWTH

Expenditures from this account have increased over 300% cumulatively since its inception, from \$9.4 million in FY80 to \$38.9 million in FY85, representing an average annual increase of almost 33%. This growth trend is expected to continue in FY86 and FY87 and makes the MA-MH account the fastest growing item in the Medicaid budget. Expenditure growth of this magnitude results primarily from three sources:

- o Provider rate increases, due in large part to inflation. The effect of inflation on this account has paralleled the rate of general health care inflation over the last few years, averaging approximately 8% per year from FY82 to FY85. In some instances, however, provider rates on average have increased at a substantially greater rate than the rate of inflation. In addition to inflation, factors such as cost-based reimbursement, rates based on budgeted costs, and provider specific rates, described below, have contributed to these rate increases.
- o Rapid expansion of community-based programs, resulting from continued deinstitutionalization of residents of DMH facilities, much of which is a result of the Consent Decrees. For instance, the Department spent \$300,000 in FY80 for 16 ICF/MR beds in 2 facilities; in FY87 the Welfare Department expects to fund 315 ICF/MR beds in 40 facilities at a cost of \$14.8 million.
- o Increase in utilization of community mental health services, particularly mental health centers. Unlike program expansion or rate inflation, this source of growth is difficult to quantify. However, during FY86, the Department expects to utilize the MMIS utilization reporting subsystem to do a more detailed analysis of utilization trends and their impact on MA-MH expenditures. In FY87, results of this analysis will be useful in designing methods to ensure that utilization of mental health services is both appropriate and necessary.

Following is a discussion of the sources of and potential solutions to the problem of rapid MA-MH expenditure growth.

Rate Increases

Medicaid rates for mental health and mental retardation service providers are set by a variety of methods and all are approved by the Rate Setting Commission (RSC). The predominant methodology used to determine MA-MH provider reimbursement is cost-based: this type of system recognizes as reimbursable virtually all costs providers incur in delivering care to recipients. At first examination, cost-based reimbursement seems entirely reasonable. The problem with the system is the relative absence of incentives to contain costs or to promote efficiencies. In fact, because future reimbursement rates are a

function of costs incurred in an earlier base year, providers have an incentive to spend as much as possible.

Mental health center and psychiatric day treatment rates are set by the RSC, which assigns "class rates" to both provider types. Each provider receives the same rate for a given unit of service (i.e., hour, day, session, etc.) Rate increases for these two provider groups have reflected the general health care inflation rate in recent years. Day habilitation programs and ICFs/MR receive individually negotiated, provider-specific rates. The Department negotiates each day habilitation rate directly with the provider and then submits the rate for RSC approval. During the period FY82 to FY85, rate increases resulting from this method averaged almost 7% annually. In FY86, the Department proposed that day habilitation programs move to a "class rate" system similar to mental health centers and psychiatric day treatment programs, in an attempt to keep average rate increases consistent with general health care inflation. In January 1986, the Department began discussions with the Rate Setting Commission to implement this change in reimbursement methodology.

Substantial rate increases have also been evident for ICFs/MR. The average FY85 ICF/MR rate represented a 12.6% increase over the FY84 Type A average per diem of \$127. The ICF/MR rate-setting methodology is somewhat different from that for day habilitation providers. For the first two years an ICF/MR is in operation, rates are based on projected costs contained in the provider's budget submissions to the RSC. According to the Rate Setting Commission, until the third year there is not sufficient cost history on which to base prospective rates. However, after this initial two-year period, the RSC utilizes actual historical cost data in setting new rates. Given that the majority of the existing ICFs/MR were established in FY81-FY83, the effect of the transition to historical data was first evident in FY84, when the average per diem for existing type A facilities actually decreased by 5%. Lower than anticipated rates resulted because historical data indicated that actual costs were in fact lower than originally budgeted costs. Despite the potential for a one-time decrease in ICF/MR rates due to the transition to cost-based reimbursement, this method, as noted earlier, does not encourage providers to contain costs in the long term.

As cost history becomes available for new programs, slower aggregate growth in ICF/MR rates should be evident. It is important to note that this will affect rates only for existing facilities that have been in operation for more than two years. For the 11 new programs projected for FY86 and FY87, actual cost-based rates for these facilities will not be in effect until FY89 and FY90.

Another aspect of the ICF/MR rate-setting process changed in FY85. In previous years, the Welfare Department, DMH, and DPH had minimal influence on rate negotiations. Effective October 1, 1984, the RSC adopted a regulatory provision requiring formal DMH, DPH, and Welfare Department approval of an ICF/MR budget before it is submitted to the Commission. This arrangement has allowed the Welfare Department more

influence over ICF/MR rates, which have a substantial impact on spending in this account.

Until this year, community ICF-MRs were all vendor-operated and funded through the Department's Medical Assistance-Mental Health account. In late FY86, the Department of Mental Health is expected to open the first of 29 state-operated community ICFs/MR. In planning these projects, DMH developed a cluster model which would involve the operation of several ICFs/MR as satellites of one of the state schools. This model would enable the cluster ICFs/MR and state schools to share some overhead and support costs. Though these state-operated facilities will be funded by DMH, it may also be feasible for existing vendor-operated ICFs/MR to utilize cluster resources, thereby decreasing their total costs and resulting rates.

B. Program Growth

A second factor directly affecting expenditure growth in the MA-MH account is the rapid expansion in the number of mental health and mental retardation service providers. To become eligible to receive Medicaid reimbursement, mental health and mental retardation programs must satisfy a variety of certification and licensure requirements, which differ for each MA-MH provider type, as described above. The relative ease of the certification process has a clear impact on the rate of program expansion within this account. Of the provider groups funded through this account, only one major provider, mental health centers, are subject to the Determination of Need (DoN) process. The DoN process is a legislatively required Department of Public Health review to assess the need for additional health care resources. However, despite the recent development of planning guidelines, there remain no quantitative standards to assess the need for additional community mental health centers. Therefore, this review process is problematic. Applications for new mental health centers are judged solely on the ability to meet certification and licensure requirements. Once providers have successfully completed the DoN process, they are eligible to provide services without first demonstrating that a need for these services exists. In a sense then, "Determination of Need" for mental health centers is a misnomer for what amounts to an administrative certification process. Other provider types in the account are not even subject to this minimal review.

Unrestrained growth in the number of mental health centers, in particular, contributes directly to MA-MH expenditure growth as each mental health center, when fully operational, adds approximately \$160,000 annually to MA-MH spending. Between FY80 and FY85 fifty-two new centers were certified across the state, increasing the total to 122. Total annual mental health center costs funded through this account more than doubled from \$7.5 million to \$18.2 million during this period.

Moreover, day habilitation providers are not subject to any type of need assessment prior to becoming Medicaid providers. The lack of

quantitative need standards has very likely contributed to faster than appropriate growth in the number of these programs. During the period FY80 to FY85, 20 new day habilitation programs became eligible to receive Medicaid reimbursement. It is clearly difficult to develop need standards for mental health and mental retardation services. However, expenditure growth in this account indicates that an effort to develop such standards should be made by the EOHS agencies involved in mental health services delivery.

A second issue is that programs may become more medically intensive and expensive than is necessary to meet clients' needs, in order to qualify for Medicaid reimbursement. Significant investments must be made in a program's physical facilities, treatment techniques, and medically trained staff. For instance, an FY85 conversion of a DMH-funded community residence to a Medicaid-funded ICF/MR resulted in increased costs to the state. As a community residence the annual cost to DMH would be approximately \$100,000. The facility now receives Medicaid reimbursement of approximately \$242,000 annually. Given that approximately 50% of the Medicaid cost is reimbursed by the federal government, the net state cost is \$121,000 annually. Clearly, conversion of this program to Medicaid funding does not save the state any money. Conversion of existing DMH residential and day programs to ICFs/MR and day habilitation programs and development of new programs must proceed carefully to ensure that adoption of a more medically-intensive service delivery model is both appropriate for clients and cost effective.

C. Utilization

Though rate increases and program expansion are more easily quantified contributors to expenditure growth, increased utilization -- particularly of community mental health services -- is also an important factor. As is the case with other health care service providers, the fee-for-service method of reimbursement creates an incentive for providers to deliver more expensive care. Additionally, reimbursement with little or no limit on the amount of care provided creates an incentive for providers to render a greater number of services. This often results in inappropriate and/or excessive utilization.

Community mental health providers, in particular outpatient mental health centers and psychiatric and acute hospital outpatient departments, are subject to few Medicaid limitations on the quantity of services reimbursed. Department regulations, including the acute hospital outpatient department regulations published in September 1985, allow 26 visits within a six-month period with prior authorization required for any visit beyond the initial 26. Ninety-one percent of "prior approval" requests are either approved or modified and then approved. When compared to other payers' mental health benefits, 26 visits/6 months or 52 visits/year at an annual cost of \$2,500 is quite generous. Blue Shield of Massachusetts limits outpatient mental health coverage to the legislatively mandated \$500 per year and the Harvard Community Health Plan covers

20 visits per year per enrollee. Both payers also include a co-insurance and/or deductible requirement with this benefit.

Additionally, despite the very modest limits on the quantity of services reimbursed by Medicaid, no Department utilization review process exists for outpatient mental health services. Clearly, the provision of mental health care is a sensitive area of health care in which objective analysis is often difficult. However, as with any health care service provided to individuals, be they recipients of Medicaid, subscribers of Blue Cross/commercial insurers or members of HMOs, third-party payers are increasingly taking on the responsibility of ensuring that services provided are necessary, appropriate, and delivered in the most cost-effective setting possible.

In the past, a lack of data has been the major barrier faced by the Department in assessing mental health utilization. Implementation of the Medicaid Management Information System (MMIS) has provided much more extensive and reliable data than previously available. The system's Surveillance and Utilization Review Subsystem (SURS) is one tool for analyzing the utilization of mental health services. In particular, the Department will be able to analyze and compare both treatment and utilization patterns across different provider types and among providers in any one provider type. For instance, reports generated by SURS and other data bases will identify providers whose treatment patterns include exceptionally high frequencies of visits compared to the norm for similar providers. Likewise, the system can identify recipients who tend to be utilizing significantly more mental health services than others in a peer group with similar characteristics. Thus SURS will be providing the Department with specific statistical data on which to develop appropriate and effective methods of controlling the high cost -- both from a fiscal and quality of care perspective -- of inappropriate and unnecessary utilization.

In recent years, a number of other payers, as well as employers who purchase mental health coverage for their employees, have become concerned with the rapid increase in the cost of mental health benefits. For instance, last year Blue Shield of Massachusetts attempted to limit the psychiatric diagnoses for which the company would provide reimbursement and to impose a utilization review mechanism to ensure that payment was issued only for necessary psychotherapy. In another example, employers choose to contract with firms such as Preferred Health Care of New York to provide second opinions on the need for and coordination of mental health care provided to employees. Another solution advocated by a provider group, the Massachusetts Psychological Association, is client "co-payment" for mental health services. Proponents of this approach contend that it is a disincentive to overutilization, and an important therapeutic technique.

Provider education, revised prior authorization requirements, utilization review, and second opinions are among the solutions to the costly problem of overutilization of mental health care that the

Department will explore in FY86, for possible implementation in FY87. Another initiative that would ensure more appropriate utilization while also providing potential savings is coordinated mental health care. Under such a program, each community mental health center or other provider would be designated the single point of entry to the full array of mental health services for recipients in that area; it would provide or arrange for community-based mental health services and serve as the point of referral for persons in need of institutional care.

Inappropriate utilization of ICFs/MR and day habilitation programs also contributes to the growth in expenditures in this account. Department regulations prohibit reimbursement after three years for residents in Type A ICFs/MR unless a determination is made that continued stay will allow future movement to a less intensive setting. However, over the years the ICF/MR program has been in operation very few beds have ever become available because of client movement, even though recent Department of Public Health reviews of client care and appropriateness indicate that some clients residing in Type A facilities are inappropriately placed. Many vendors report that there are clients who could move to less intensive (and less costly) settings, but placements in DMH-funded community residential programs are not currently available. Similarly, clients often remain in day habilitation programs longer than clinically necessary, or move from one day habilitation program to another due to the lack of appropriate, less intensive placements.

In FY87, the Department will continue to work with DMH to ensure that all ICFs/MR and day habilitation clients are appropriately placed. To facilitate movement of recipients into more appropriate settings the Department will work with DMH to develop additional, less intensive community programs.

D. FY87 Request

The Department expects to spend \$44.8 million for community mental health and mental retardation services in FY86. Provider rate increases and program expansion will occur in FY87, resulting in a projected total cost of \$53.1 million. Therefore, the Department is requesting \$53.1 million to fund the MA-MH account in FY87.

MEDICAID-MENTAL HEALTH PROGRAM EXPANSION

	FY84		FY85		FY86		FY87	
	# of Programs	Expenditures	# of Programs	Expenditures	# of Programs	Expenditures	# of Programs	Expenditures
ICF-MR Type A	5		13		23		24	
Type B	<u>12</u>		<u>16</u>		<u>16</u>		<u>16</u>	
Total ICF-MR	17	\$ 5,106,000	29	\$ 7,772,000	39	\$12,020,099	40	\$14,784,895
Day Habilitation	23	3,788,000	26	6,439,000	31	7,477,904	36	10,764,633
Mental Health Center	120	15,389,000	122	18,198,000	127	18,733,432	132	20,357,261
Psychiatric Hospital OPD	7	2,607,000	7	3,001,000	7	2,725,341	7	2,842,570
Psychiatric Day Treatment	28	1,621,000	30	2,368,000	32	2,509,325	33	2,889,926
Early Intervention	--	--	44	200,000*	47	1,367,932	50	1,510,368
TOTAL		\$28,511,000**		\$37,978,000**		\$44,834,033		\$53,149,653

* Early Intervention services became Medicaid-reimbursable in the final quarter of FY85.

** Based on Department's expenditure reports.

GENERAL RELIEF HEALTH SERVICES (4406-5000)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures	\$6,974,061*	\$9,575,000	\$14,396,000**	\$16,000,000

INTRODUCTION

The General Relief health services program provides medical benefits to General Relief (GR) recipients: needy individuals who are ineligible for other welfare programs such as AFDC or SSI. As is true for the GR cash assistance program (4406-2000), the health services program is funded entirely by the state.

GR recipients, including approximately 1,500 families, are among the Commonwealth's most vulnerable citizens: more than 56% of the caseload, about 13,800 recipients, qualify for assistance based on a physical or mental disability, and approximately 700 recipients are homeless.

In response to a growing recognition that many of the health care needs of this vulnerable population were not being adequately met through the existing GR health program, the administration, in cooperation with the legislature, broadened considerably the package of health services available to this population in FY85. A 37% increase in spending from FY84 to FY85 (detailed later) suggests that the expanded program is appropriately addressing a critical need of the GR population.

In FY86, the first full year of this expanded benefits package, the Department will implement additional initiatives designed to complement the new services -- with the ultimate goal being access to and appropriate utilization of a comprehensive range of health care services, and better overall health for GR recipients.

In FY87, the Department is requesting authority to spend \$16 million to fund medical and related services for the GR population. Funding for these services will be provided through the GR health (4406-5000) account, which was established beginning in FY86 to separate payment for GR health services from the GR cash assistance program account. Creating a distinct account enables the Department to monitor more effectively medical services provided to the GR population.

* Funded through General Relief program account (4406-2000) prior to FY86.

** Projected spending.

GR HEALTH SERVICES PROGRAM HISTORY

Prior to FY76, GR recipients were entitled to a package of health care benefits comparable to those received by Medicaid recipients. These benefits included acute hospital and institutional long-term care. Due to fiscal constraints, however, payment for all GR health services was discontinued in December 1975. From that point through FY84, some ambulatory care services were gradually restored. By the beginning of FY85, GR recipients were eligible to receive a limited package of noninstitutional ambulatory care services. These services included: physician services and dentistry (provided in a freestanding clinic or private office only), durable medical equipment, home health services, vision care, life-sustaining medications, and primary care in community health centers.

Recognition in recent years that the limited benefit package did not adequately meet the health care needs of the GR population resulted in the legislature appropriating additional monies to fund an enhanced health services package in FY85. These new benefits include: an expansion of the basic ambulatory benefit package, the opportunity to enroll in coordinated health programs, and a guarantee of access to acute hospital benefits through an agreement included in Chapter 347 of the Acts of 1984.

In FY86, the Department has established a series of initiatives designed to complement this package. Such activities focus on providing health care for the homeless and assuring successful implementation of the acute hospital access agreement.

DEVELOPMENTS: FY84-FY86

Efforts to improve health care services for GR recipients in the period FY84 through FY86 included the following key developments:

- o enhancement of the package of ambulatory care benefits;
- o enactment of legislation which guarantees access to acute hospital services for GR recipients;
- o initial efforts to monitor carefully GR recipients' access to acute hospital services;
- o payment for the services of health care professionals who are not salaried by a hospital in order to improve access to acute hospital services;
- o implementation of two initiatives to enhance the provision and quality of health care to the homeless;
- o eligibility for coordinated health programs; and
- o provision of a limited package of ambulatory mental health benefits.

A. Implementation of Expanded Ambulatory Care Benefits

As of December 1985, the following services provided in ambulatory medical care settings are available to GR recipients:

- | | |
|------------------------------------|--|
| o Physician Office Visits | o Full Pharmacy Services* |
| o Community Health Center Services | o Transportation to Covered Services* |
| o Dental Care | o Eye Examinations and Eyeglasses |
| o Podiatry* | o Rehabilitation Center Services |
| o Laboratory Tests | o Physical, Occupational, and Speech/Language Therapy* |
| o X-rays | o Speech and Hearing Center Services* |
| o Private Duty Nursing* | o Mental Health Services (provided by DMH) |
| o Home Health Care | |
| o Psychological Testing | |
| o Durable Medical Equipment | |
| o Hearing Aids | |
| o Family Planning Services* | |
| o Chiropractic Services + | |

* Services restored in FY85; pharmacy previously covered just life-sustaining drugs.

+ Added in FY86.

This comprehensive package of noninstitutional services, funded at 100% state cost, is essentially comparable to the noninstitutional benefits available to Medicaid recipients. The outpatient mental health care GR clients receive is provided and funded by the Department of Mental Health.

It is important to note that the addition of seven services is more than simply an incremental improvement. Of greater importance is the fact that GR recipients are now able to receive a complete range of ambulatory services. This enables more appropriate utilization of medical services instead of the piecemeal services available previously. Further, physicians may be more willing to make referrals to specialists and other types of providers when necessary, since the recipient's financial status will no longer be a barrier to the continuation of a care plan.

B. Acute Hospital Services Agreement

GR recipients now have access to the same full range of acute hospital care available to Medicaid recipients. This access is guaranteed through an agreement negotiated between the state, the Massachusetts Hospital Association, private insurers, and the business community. In FY87, these services will be funded under the bad-debt and free-care provision of Chapter 574 of the Acts of 1985, the current version of state's hospital cost-containment law. In return, legislation enacted in December 1984 as Chapter 347 of the Acts of 1984 obligated the Department to pay \$55 million to the hospitals to correct an error in the Medicaid reimbursement formula.

C. Hospital Services Access Monitoring

As noted above, the Commonwealth does not directly fund acute hospital care for GR recipients. Thus, despite the statutory access guarantee, it is possible that members of this population may have difficulty receiving the care they need and to which they are entitled. Therefore, in FY86 and FY87, the Department will monitor access to care to further ensure that the service-provision commitment is met. Monitoring methods will include:

- o working with the Massachusetts Rate Setting Commission to collect and analyze data pertaining to GR utilization of hospital services;
- o operating a telephone access hotline through the Department to handle questions and complaints;
- o responding to access problems in area hospitals which are identified through the Department's office at Boston City Hospital;
- o meeting with hospital administrators when access problems occur; and
- o contracting with other state agencies and local organizations to participate in monitoring activities.

D. Hospital Professional Services

Another potential barrier to accessing acute hospital care was the fact that providers of hospital care not on an institution's payroll (e.g., physicians, anesthesiologists) were not receiving any compensation for their services to GR recipients, and were accordingly at times reluctant to participate. To avoid such situations, the Department began covering these providers' fees in FY86, and is requesting funds to pay for these services again in FY87.

E. Health Services for the Homeless

Making sure the homeless receive health care can be a particularly difficult problem. Accordingly, in FY86 the Department has introduced two programs -- funded through the GR health services account -- to respond to this situation.

The Robert Wood Johnson Foundation is providing a four-year, \$1.4 million grant to Boston City Hospital (BCH) to coordinate the provision of direct health services to the City's homeless. The state, through the Welfare Department, has pledged to provide \$250,000 of matching funds for each of the four years of program operation (through December, 1988). Specifically, this project has three basic goals:

- o to establish a process for the planning, management, delivery and oversight of health care services for the homeless;
- o to provide health care and social services to homeless persons in Boston through the use of three outreach health care teams coordinated by BCH;
- o to establish the capacity to meet the needs of homeless individuals for community-based recuperative care.

This program has gotten off to a promising start. From late April to mid-September, 1985, 444 homeless individuals had received health care treatment. Moreover, the method of using health teams to deliver primary care at homeless shelters and make follow-up referrals to BCH has produced many additional benefits. For example, such a method provides a continuity of care not gained when a homeless individual seeks treatment at an outpatient unit at an advanced stage of illness. And, as a by-product, this program has helped to control the traffic flow at the hospital's outpatient unit -- which often sees as many as 800 patients per day.

In addition to providing matching funds, the Department will aid the development of this program by providing information and support services. For instance, the Department reopened the Medicaid unit at Boston City Hospital to respond to the unique health care needs of a population in a geographic area with high concentration of Medicaid recipients and the working poor.

The Advocacy and Outreach program, on the other hand, consists of Department contracts with organizations across the state to fund activities geared toward enrolling eligible homeless (and other uninsured) individuals on General Relief so that they can obtain health services, informing clients of the range of health care services available to them, and helping to arrange for both provision of these services and appropriate follow-up. Ten program sites-- at least one in each of the federally-designated Health Service Areas in the state-- began operation in the fall of FY86. Initial estimates project provision of services to upwards of 4,500 persons in the program's first year.

F. Coordinated Health Program

As part of the GR health services program expansion, since FY85 GR recipients have been eligible to enroll in the Department's coordinated health programs. Coordinated health enrollees are able to choose a single health care provider (physician or community health center) which provides or authorizes all health care for that recipient. Coordinated health has two primary advantages: first, this type of delivery system helps to ensure that health care is provided cost-effectively; and second, enrollment in a coordinated health program ensures continuity of care, a key quality-of-care indicator. Ongoing, comprehensive care is particularly vital for the vulnerable GR population. Since FY85, the Department has amended 13 (of a total of 18) Medicaid contracts with coordinated health

providers to include coordinated care for GR recipients, offering a monthly management incentive to help cover any increased day-to-day operating costs. As of October, 1985, 135 GR recipients were enrolled in this program.

G. Outpatient Mental Health Services

The Welfare Department and the Department of Mental Health (DMH) have been working together to assure the GR population full access to ambulatory services provided by the network of DMH-affiliated community mental health centers. Except for certain psychological testing services, funding for such care is provided to GR recipients at no direct expense to the GR health services account, but rather is subsidized by money paid for services provided to Medicaid recipients and to other clients.

One of the most important needs of the mentally disabled among the GR population that is being met by these efforts is the provision of psychiatric day treatment services. These programs serve persons who need more active, intensive treatment than is typically available through mental health centers or hospital outpatient departments, but who do not require full-time hospitalization or institutionalization. Psychiatric day treatment programs provide therapeutic and rehabilitative services, such as individual or small group therapy, in sessions of varying length: full day, half day, and quarter day--depending on the needs of the client. Currently, 256 individuals enrolled in this program, or an estimated 14% of the "psych-day" case mix, are GR recipients.

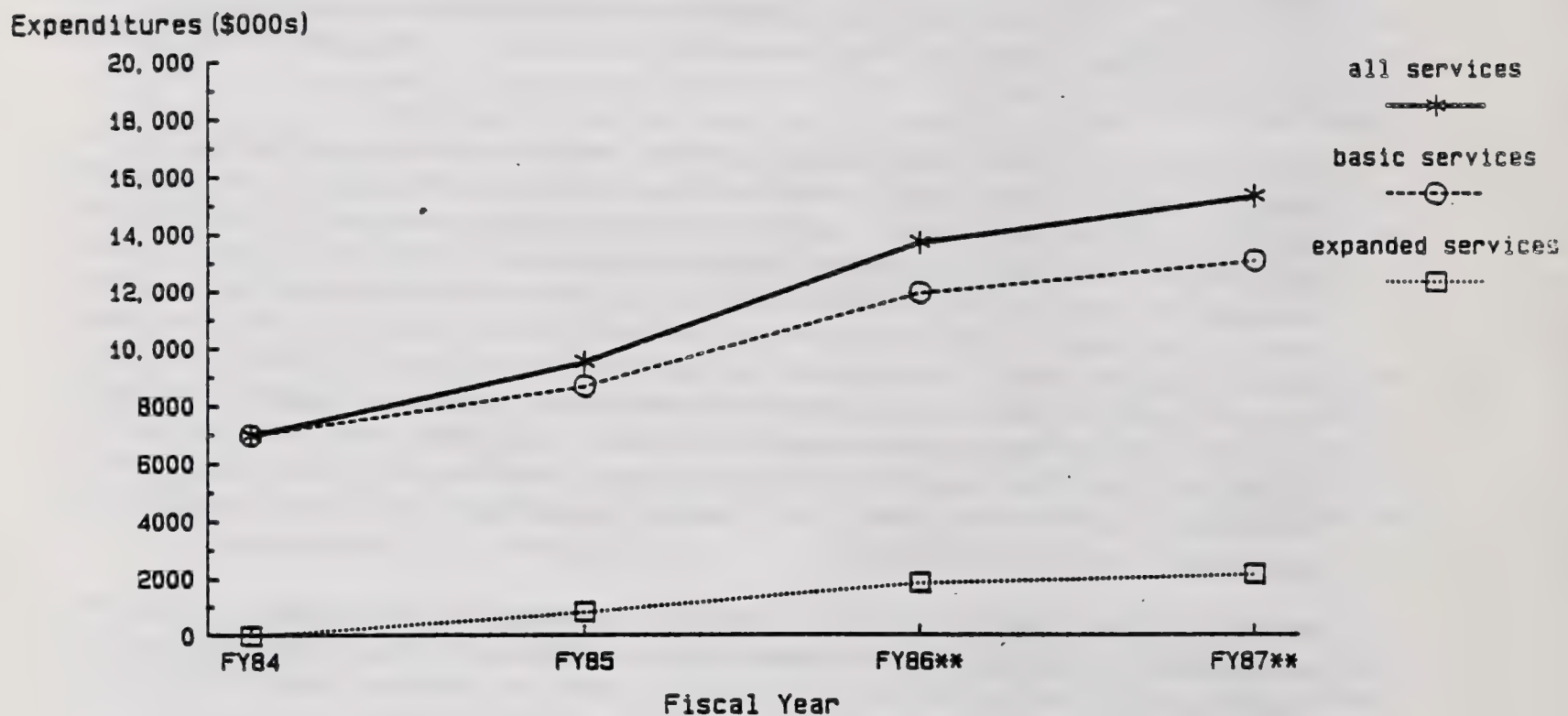
FY86 will be the first full year of operations for these and other ambulatory mental health services offered to GR recipients, and services are projected to continue at similar levels through FY87.

DISTRIBUTION OF EXPENDITURES

Spending patterns illustrate the changes which have taken place in the GR health services program over the last three years.

A. Expenditure Growth

Direct Health Services Spending*



* - includes amb. and hosp. prof. services

** - projected

Portrayed above are expenditures for direct health services -- basic and new -- to GR recipients from FY84-FY87. The table on the following page shows the year-to-year growth of expenditures over this period.

<u>Direct Health Services</u>	<u>FY84</u>	<u>Annual Percentage Expenditure Growth</u>	<u>FY85</u>	<u>Annual Percentage Exp. Growth</u>	<u>FY86*</u>	<u>Annual Percentage Exp. Growth*</u>	<u>FY87*</u>
Total Health Services Expenditures	\$7.0M	37.0%	\$9.6M	43.0%	\$13.7M	12.0%	\$15.3M
Basic Services	\$7.0M	24.0%	\$8.7M	36.0%	\$11.8M	12.0%	\$13.2M
Expanded Services	n/a	n/a	\$.9M	101%	\$1.9M	13.0%	\$2.1M

*Projected.

The growth trends are not surprising given the implementation of the expanded benefit package in November, 1984. However, the inclusion of new, expanded services does not completely totally explain the spending increase. Of particular note, spending for basic services grew in the initial period of the new program, increasing at a rate that outpaces what would have been expected based on adjustments for provider rate and caseload changes.

This growth is in part a product of the Department's efforts to inform recipients, providers, and advocates of the GR health services program. The increased use of basic services supports the view that the availability of comprehensive health benefits has promoted overall use of GR health services.

B. Expenditures by Provider-Type

<u>Major Provider-Type</u>	<u>Portion of Annual Budget</u>			
	<u>FY84</u>	<u>FY85</u>	<u>FY86*</u>	<u>FY87*</u>
Pharmacy	34.8%	33.5%	35.5%	32.5%
Physician	22.1	22.2	25.2	23.7
Dentist	21.9	21.0	15.1	14.4
Clinic/CHC	5.1	4.9	3.1	4.4
Medical Supplies	4.5	4.2	3.1	3.75
Transportation	-	2.5**	3.9	3.7
Total Portion, Top Five	88.8%	84.8%	83.4%	78.8%

* Projected.

** FY85 transportation ranking based on eight months of spending.

Listed above are the largest expenditure items in the GR health budget for FY84-FY87. Of these services, pharmacy, physician, and dental spending predominate -- making up in the aggregate between 70.6% and 78.8% of the budget over these years. Of note, however, the portion of the budget that the total of these three (and that of the total of the top five) make up has been steadily decreasing. This is not to say that actual expenditures are decreasing. Rather, it simply portrays a wider distribution of expenditures over the broadened benefit package.

FY87 AGENDA and REQUEST

FY87 will be the first year that all of the GR health program improvements which the legislature and the Department have made will be in effect for a full twelve months. The Department's FY87 activities will focus on effective management of the program's several components. The FY87 request of \$16 million is 11% more than projected FY86 spending. The FY87 forecast appears below.

FY87 General Relief Health Services Forecast

Direct Health Care*	\$15,303,000
Homeless Health**	<u>697,000</u>
TOTAL	\$16,000,000

* Includes ambulatory services, coordinated care, and hospital professional services.

** Includes funding for both the Robert Wood Johnson program and the Advocacy and Outreach program.

PROJECT GOOD HEALTH (4400-1400)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures/ Appropriation	\$1,125,729	\$1,147,404	\$1,295,420	\$1,463,027
Recipients Enrolled	55,573	86,765	120,000*	130,000

Project Good Health (PGH) is a comprehensive and preventive health program offered to Medicaid children from birth through age 20. It is the Massachusetts program of Early and Periodic Screening Diagnosis and Treatment (EPSDT) mandated by Title XIX of the Social Security Act. The PGH account funds the administrative expenses associated with promoting provider participation and expanding client enrollment in the program. Medical services provided to PGH recipients are funded through the Medicaid account (4402-5000).

During the last three years, the Department has made expansion of the PGH program a priority. The result is a large increase in the number of both providers and recipients participating in the program, as well as a broader range of the types of providers participating. In 1984, recommendations from a PGH study prepared for the Medicaid unit by the Department's Research Planning and Evaluation unit helped the program determine where to target its recruitment efforts. Recently, the Children's Defense Fund singled out for praise the Commonwealth's successful recruitment of community health centers as PGH providers. Moreover, plaintiffs in the Vega v. Moran suit, filed against the Department in 1978 to enforce federal EPSDT requirements, have dropped their contempt motion against the Department because of the large increase in the number of PGH providers and recipients throughout the state. The plaintiffs and the Department have negotiated a specific date on which the suit's stipulation, under which the program has operated since 1981, would terminate.

During FY87, PGH will continue to expand. The Department will pay particular attention to retention of current providers, recruitment of family planning agencies, identification of recipients in need of services, and an increase in the number of face-to-face meetings with recipients. All of these activities will help the program meet its objectives to:

- o ensure comprehensive health care for Medicaid eligible children from birth through age 20;
- o enable detection of health problems and provide treatment before health problems become chronic; and

* Projected.

- o educate recipients about preventive health care, family planning and nutrition.

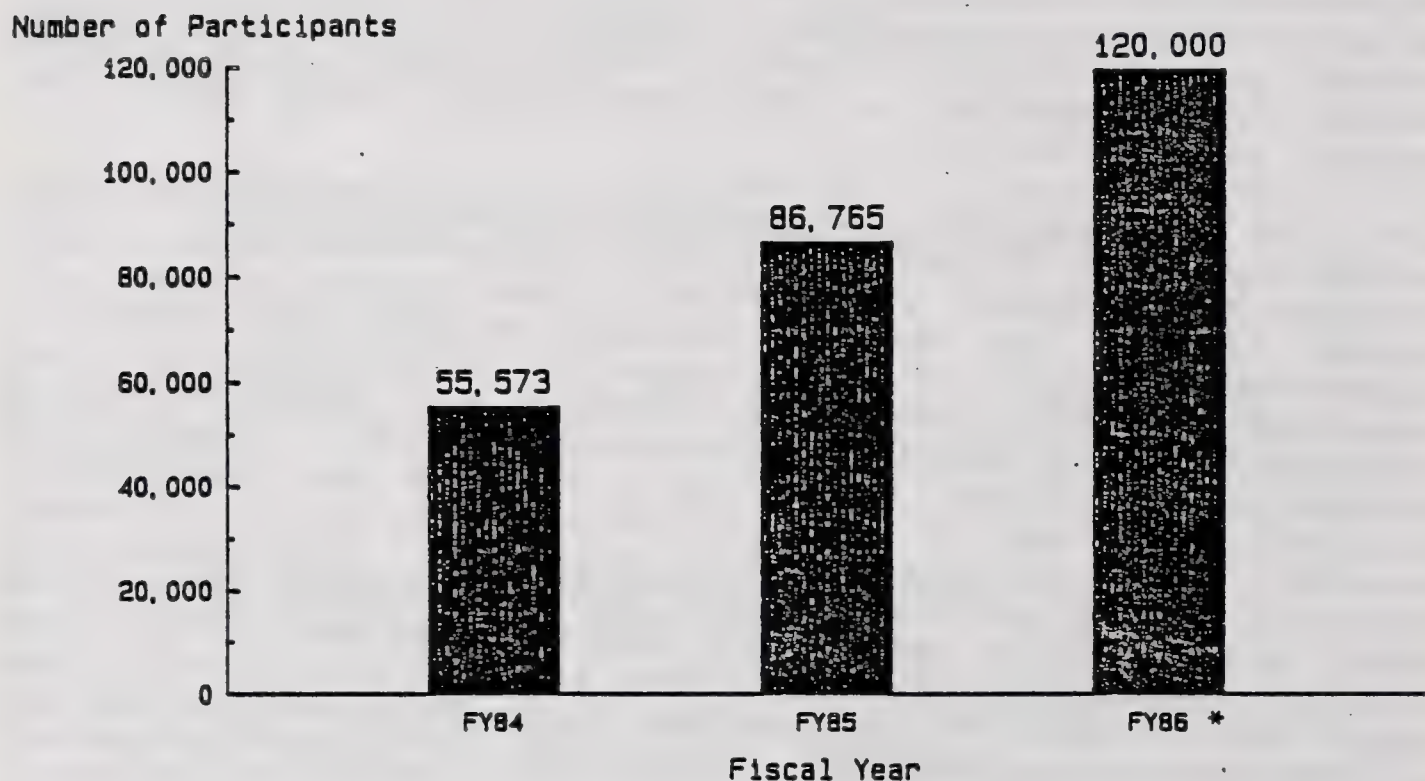
PERFORMANCE 1983 - 1986

Increased senior-level management attention to PGH , an improved marketing and outreach strategy, and legislative support are responsible for a number of important accomplishments in FY84, FY85, and the first half of FY86, described briefly below.

A. Recipient Participation

Participation in PGH has grown from 55,573 children in FY84 to 86,765 children in FY85, a 56% increase. The Department hopes to have made progress towards its ambitious goal of 120,000 enrolled children by the end of FY86. This would represent an increase of more than 100% in a two year period.

INCREASE IN PGH RECIPIENT PARTICIPATION



* Projected.

PGH has developed a number of activities to target and recruit new participants. These are described below.

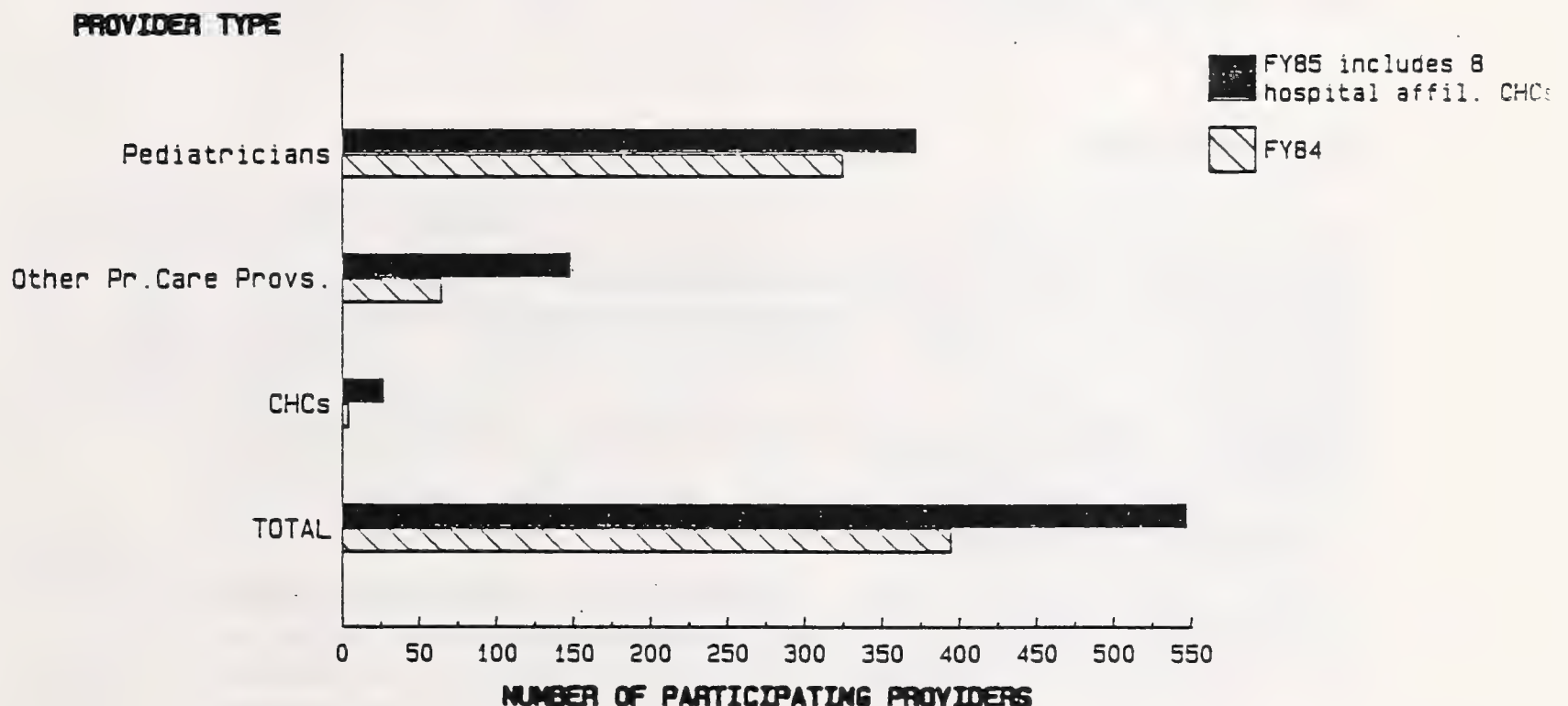
- o Informational mailings to school nurses throughout the Commonwealth elicited a response from more than 100 school systems for additional PGH information. Follow-up presentations were made to nurses in 25 school systems.
- o Presentations to more than 200 community and social service agencies who come in contact with AFDC families were made. Agencies included were hospital social service departments, family planning clinics and WIC programs.

- o Special outreach mailings were made offering a PGH cookbook incentive to recipients who completed and returned a medical and dental questionnaire. Communities targeted were Barnstable, Brookline, Chelsea, Gardner, Somerville and Worcester.
- o Procedures were developed and implemented in three area offices for PGH staff to meet with eligible recipients when they pick up their Food Stamp photo-ID cards. In Brockton, Roslindale and Quincy, photo-ID staff cooperate with PGH field staff to identify potential PGH participants and to notify PGH workers when these recipients come in for their cards. The PGH workers include a brief message about PGH on the letter that tells the recipient when to pick up his or her card, extending an invitation to meet with a PGH worker.
- o Cooperation with a coalition in Holyoke, an area with a severe ob-gyn access problem, resulted in a new health clinic for teenagers in the high school. Doctors staffing the clinic are PGH providers.

B. Provider Participation

Recruitment efforts have resulted in 547 providers participating in PGH at the end of FY85. This represents an increase of 154 providers, or 39%, over FY84.

INCREASE IN PGH PROVIDER PARTICIPATION BY TYPE OF PROVIDER



During FY85 and FY86, PGH provider recruitment staff contacted all PGH providers to offer assistance and confirm continued participation in the PGH program. Such retention strategies are an important complement to recruitment efforts. The latter include:

- o Completion of a PGH-requested modification to the Medicaid Management Information System (MMIS) claims processing system that enabled two large hospital-based group practices to participate in PGH.
- o Recruitment of community health centers (CHCs), which has resulted in the participation of 19 independent CHCs. The Department supported a \$2 PGH rate increase for CHCs in FY85. Reimbursement for a PGH exam is \$48, as of July 1, 1985.
- o Development of an amendment to the Medicaid provider agreement to enable hospital-affiliated CHCs to participate in PGH. Five hospitals, representing 12 health centers, have signed such agreements. The hospitals are Boston City Hospital, Carney Hospital, Massachusetts General Hospital, Somerville Hospital and Wing Memorial Hospital.
- o Inclusion of PGH requirements in the new acute hospital outpatient department (OPD) regulations promulgated by the Department. Clinicians in OPDs providing well-care services to PGH eligible children are now required to follow the PGH protocol.
- o Completion of a PGH requested modification to MMIS to enable family planning agencies to participate in PGH without breaching the confidentiality of their patients.
- o Review of DSS health forms on individual children to target recruitment of physicians who are seeing DSS children but not participating in PGH.

FY87 OBJECTIVES

In FY87, the Department will focus on the quality of care delivered by PGH providers, as well as on continuing to recruit non-participating providers and recipients and expanding the service delivery system. The Department will continue to aggressively encourage providers to remain in PGH, through such means as technical assistance. The PGH protocol and periodicity schedule will be revised to reflect current pediatric practice. The initiatives discussed below should enable the program to accomplish its objectives.

A. Recipient Participation

The Department will seek to increase recipient enrollment to 130,000 in FY87 through the following initiatives:

- o Cooperative efforts with photo-ID staff will be expanded to additional area and branch offices in order to increase face-to-face meetings with eligible families.
- o Modifications to the MMIS claims processing system will be made to enable PGH to more effectively monitor receipt of preventive health services by Medicaid recipients under 21 years of age. PGH will thus be able to target for outreach and assistance those individuals who have not received all appropriate preventive health services within the PGH recommended periodicity schedule. In this way, the program can more appropriately assign resources and design initiatives to improve service delivery in those areas where utilization is low. The monthly report to be generated will also give Department staff a more effective tool to monitor the program's overall effectiveness in improving access to preventive health services for children and adolescents.
- o The Department will work more closely with pre-school and day care programs to enroll children in these programs in PGH through the school or day care center. The Department will continue efforts already underway to inform Headstart and other pre-school and day care programs about Project Good Health services.
- o The Department will identify school systems that offer comprehensive health care to students. Staff delivering these services will be recruited into the PGH program.
- o The Department will work with the Departments of Public Health and Education to develop a plan for referring to PGH school-aged children who are not receiving regular health care.

B. Provider Participation

The Department will continue to aggressively recruit and retain a broad range of health care professionals in PGH through the following initiatives:

- o The Department will expand its Quality Assurance Review (QAR) program for PGH providers. During FY86, a preliminary process is being developed and tested. In FY87, the QAR program will be refined for broader implementation among the provider population.
- o Based on results of the QAR, the Department will develop technical assistance for PGH providers to support them in their efforts to provide high-quality health care services to PGH participants.
- o The Department will develop alternative administrative mechanisms to enable providers delivering preventive health care services in non-traditional settings to participate in PGH. Such settings

might include Job Corps sites and pre-school and day care programs.

- o The Department will target recruitment on those providers who do not submit Medicaid claims in the traditional manner. HMOs, group practices delivering fee-for-service health care to Medicaid recipients, and hospital-based group practices are three such types of providers.
- o The Department will develop and implement programs for hospital outpatient departments (OPDs) to educate clinical staff about the PGH program. Under OPD regulations promulgated in FY85, OPDs offering well-care services to PGH eligibles must follow the PGH protocol and periodicity schedule.
- o The Department is negotiating with the Department of Public Health so that contracts with sites receiving Title V Children and Youth funds incorporate the PGH protocol and periodicity schedule.

PGH SERVICES

A. Outreach

When a family is determined eligible for AFDC, the PGH staff, located in local Welfare offices throughout the state, inform the parent about PGH services and offer assistance in obtaining these services. If the parent is interested, more intensive case management activities are provided to all recipients who request them. Particular attention is given to those who do not already have a regular family physician or dentist, or who have special health problems. The PGH field staff provide outreach in the form of special mailings, telephone calls, and home visits. An FY85 Department survey of PGH-eligible families indicated that nearly 75% of the individuals questioned were aware of the program.

In addition to performing basic outreach activities, PGH staff also focus on improving access to preventive health care for segments of the population for whom underutilization of care and vulnerability to health risks are prevalent. PGH staff use data available from MMIS and from agency analyses to target marketing initiatives to these groups.

In FY84, PGH staff concentrated on promoting and increasing awareness of nutrition among the PGH population. These efforts focused on those groups most vulnerable to the problems associated with poor nutrition: Southeast Asian refugee families who, according to statistics, are at increased risk of malnutrition; and pregnant women, since their nutrition directly affects the health of their unborn children. Specific initiatives included:

- o producing a cookbook (jointly with the Expanded Food and Nutrition Program and the Department of Education), which

provided information on nutrition education and recipes designed to assist families in stretching limited budgets.

- o translating PGH literature into Laotian and Cambodian, for two of the fastest growing refugee populations in Massachusetts.
- o co-sponsoring with the Department of Public Health and the Massachusetts League of Community Health Centers a workshop for clinicians on "Improving Pregnancy Outcomes". The workshop was offered in Springfield, Worcester and Boston.

B. Assistance and Monitoring Services

Once PGH workers have informed recipients about PGH through marketing efforts, they continue to ensure access by assisting participants in obtaining medical and dental care. The services PGH staff provide include guidance in selecting providers, scheduling appointments, and assistance with transportation and child care arrangements.

In FY85, PGH staff, in cooperation with other human services agencies, produced a Medical Passport, which records the services children get. The passport also incorporates the PGH protocol and periodicity schedule (a schedule of check-ups and preventive health measures). Currently, children in the care of the Department of Social Services (DSS) carry the Medical Passport. The goal of this project is to improve the quality and ensure the continuity of care received by DSS children. The Medical Passport project is expanding to include children in the care of the Department of Youth Services and the Department of Mental Health.

RECIPIENT ENROLLMENT

Despite a significant decline in the AFDC and AFDC-related caseloads, the number of children in PGH has increased steadily in recent years. In FY84, program enrollment grew from 44,375 to 55,573 recipients, representing a 25% increase. The proportion of eligible recipients who were enrolled in PGH grew from 20% to 25%. In FY85, enrollment grew to 86,765, representing a 42% participation rate and a 56% increase over the previous year.

The Department seeks to increase enrollment by 38%, to 120,000, by the end of FY86. An annual increase of this size will result in the enrollment of 56% of the total eligible population. The FY87 goal is enrollment of 130,000 recipients, representing about 60% of the projected eligible population.

PGH PROVIDER RELATIONS AND PROVIDER PARTICIPATION

In addition to enrolling recipients, ensuring that there are a sufficient number of PGH providers across the state is an important component of the PGH program, as access to regular health care for recipients is dependent upon the number of physicians participating in PGH.

PGH requires physicians to perform a more thorough examination than an average physical examination would entail. The physician initially performs a comprehensive physical examination that includes a number of different tests or "screens". Thereafter, the physician provides routine check-ups at regular intervals, and treats, or refers for treatment, any diagnosed problems.

Physician participation in the Medicaid program is voluntary. Moreover, providers who participate in Medicaid are not required to enroll in PGH. Achieving new enrollment frequently requires considerable education and outreach efforts with providers. Nonetheless, in FY84, the Department met its goal by increasing PGH provider participation from 330 to 393 practitioners. In FY85, the number of providers was increased to 547, representing an increase of about 39% over FY84.

Despite a large increase in enrollment of physicians in PGH since 1981, provider recruitment and retention continue to be major initiatives. In fact, the single most effective strategy to increase PGH recipient enrollment is through targeted recruitment of physicians and other providers. This strategy responds to findings which revealed that a substantial portion of Medicaid-eligible families receive regular well-child medical and dental care outside of PGH. Thus, the data suggest that one key to increasing PGH recipient enrollment is to recruit providers who, while not enrolled in PGH, currently provide care to Medicaid families.

In order to meet FY86 and FY87 PGH provider participation goals, the Department intends to continue:

- o to extend financial incentives to increase participation;
- o to simplify administrative billing procedures; and
- o to execute a marketing strategy which emphasizes recruitment of nonparticipating primary care providers, including those who are located in medically under-served areas.

The Department will continue to place special emphasis on enrolling hospital-affiliated health centers, family planning agencies and other alternative providers.

The major FY85 and FY86 marketing, financial, and administrative initiatives to increase PGH provider participation are summarized below.

o Marketing

In FY85, PGH reopened negotiations with the Massachusetts Association of Family Planning Project Directors to develop procedures which will enable family planning agencies throughout the Commonwealth to offer PGH services. The high teenage pregnancy rate and the high risks of infant mortality and low-birth weight which studies have associated with teenage mothers, particularly low-income women, warrant an increased commitment to ensuring adolescents access to basic family planning information and services.

o Financial Incentives to Providers

During FY85, PGH recruitment activities focused on community health centers. Continued efforts to increase CHC participation are important, since survey findings suggest that about 25% of Medicaid families utilize CHCs as their regular source of medical care. In order to attract more community health centers, which generally already serve sizable numbers of PGH-eligible children, in March 1984 the Department increased the PGH rate per CHC visit to \$46, significantly higher than the rate for a non-PGH visit. The rate was raised to \$48 as of July 1, 1985. In FY85, the Department successfully recruited 14 additional community health centers, bringing the total enrolled to 19. An additional 12 hospital-affiliated health centers now participate.

In FY86 and FY87, the Department will also continue to offer a higher Medicaid rate for PGH visits to physician offices than for non-PGH physical examinations, since PGH requires physicians to perform a more thorough examination and requires more extensive documentation than an average physical examination would entail.

o Administrative Flexibility

The Department will continue to develop alternative reporting systems for providers whose current administrative systems preclude them from fulfilling PGH billing and reporting requirements. With continued expansion of alternative PGH provider arrangements, an increasing proportion of the eligible population (particularly those Medicaid families who are already affiliated with providers) will have the opportunity to benefit from PGH.

COST CONTAINMENT

In addition to providing quality health care to children, the Department believes that the PGH program has helped to contain Medicaid costs for children, and that children enrolled in PGH have fewer health problems than non-enrolled Medicaid children because of the preventive health care services which PGH provides.

National statistics on Medicaid expenditures consistently demonstrate the cost effectiveness of the EPSDT program as a preventive health tool. Since the inception of EPSDT guidelines, the pattern of expenditures of

outpatient hospital services across all states has changed dramatically. Measured in both total dollars and expenditures per recipient, children's use of outpatient services exceeded adults' through 1975. Thereafter, adult utilization and costs have accelerated, while those of children have remained constant.

Similarly, acute hospital inpatient expenditures for children are significantly lower than expenditures for adults through the most recent year for which figures are available. Also, the average inpatient expenditure per adult recipient was two and one-half times greater than the average expenditure per child recipient. Moreover, an EPSDT study documents that EPSDT participants have Medicaid costs (including administrative costs) that are about 7% lower than Medicaid costs for non-participants.

The PGH program promotes cost containment in two ways: first, the comprehensive physical examinations that PGH-enrolled children undergo on a regular basis allow physicians to detect and manage health problems in their early stages, before conditions become more difficult and expensive to treat; second, the continuing, preventive health care provided by PGH physicians reduces utilization by PGH children of costly hospital emergency rooms and other outpatient department services.

FY87 REQUEST

1. (01) personnel	\$576,275
2. (02) personnel	<u>886,752</u>
Total Request	\$1,463,027

The FY87 PGH request includes funds for 68 staff, including 59 field staff, who provide direct services including outreach, assistance, and follow-up to Medicaid families eligible to participate in the PGH program. Federal reimbursement covers 75% of PGH administrative costs. Major initiatives for FY87 include: increasing recipient enrollment; continuing the implementation of a Quality Assurance Review program; continuing provider retention activities; exploring linkages with school health programs and providers in other non-traditional settings who deliver primary-care services.

The PGH account funds the staff and other administrative expenses required to meet federal regulations, the terms of the Vega v. Moran suit, and the Department's enrollment goals. Regulations governing the Massachusetts PGH program require that AFDC families be informed about PGH services on a face-to-face basis and/or in writing no later than 60 days after they are determined to be eligible for Medicaid. If, after being informed, a recipient requests PGH services, the Department must

ensure that, within a reasonable period of time, the recipient receives: an initial "screening", or comprehensive physical examination; any treatment that is needed as a result of the initial screening; and periodic rescreening as specified in the EPSDT "protocol", or health assessment guidelines. (These guidelines are included in the statistical appendix at the end of this volume.) Federal regulations further require that any recipient who requests services must be offered assistance in scheduling medical or dental appointments and arranging transportation to and from appointments. Under the court stipulation signed by the Department in the Vega v. Moran suit, assistance with child care arrangements, counseling, and translation services must also be available to recipients requesting PGH services.

PRODUCTIVITY, MANAGEMENT, AND SERVICE DELIVERY

The Department of Public Welfare, on a monthly basis, provides cash and medical assistance to more than half a million people in the Commonwealth. Additionally, the Department makes available various services designed to improve the quality of life of recipients and to assist them in moving out of poverty. While these benefits and services are funded through program accounts, their provision is funded through administrative accounts. Determining eligibility for medical and cash assistance, providing Emergency Assistance to eligible recipients, enrolling children in the Project Good Health program, providing transportation and day care for AFDC recipients enrolled in the Employment and Training program, and getting checks to recipients and medical providers requires staff, computers, office space, equipment, supplies, phone systems, and other support resources.

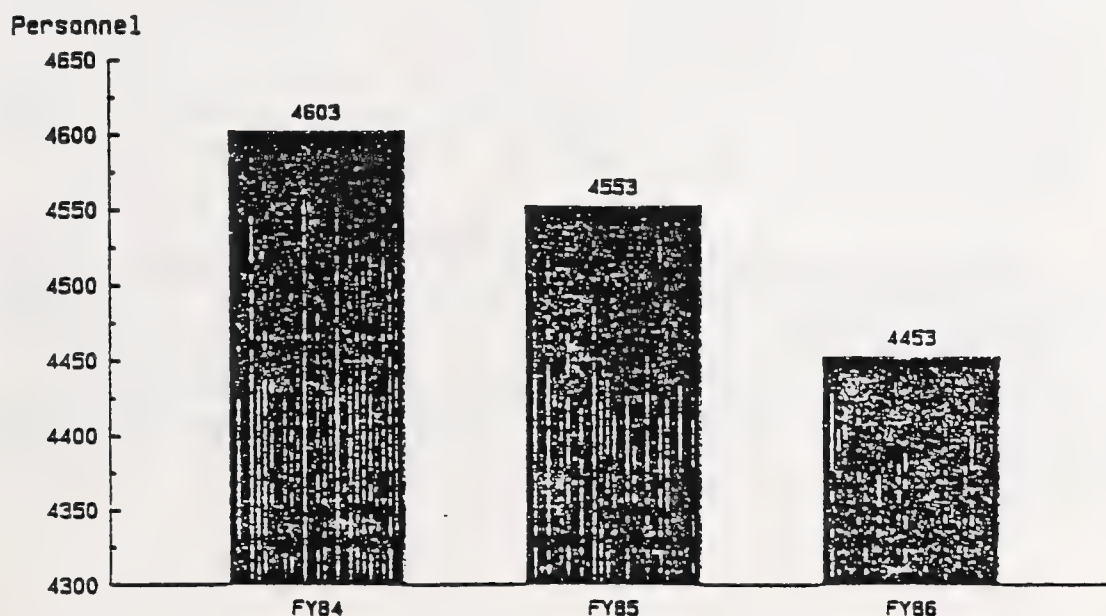
In addition to supporting the provision of benefits and services, administrative accounts also support the agency's management agenda. The level of administrative funding provided is, to a significant extent, a determinant of agency performance.

IMPROVED PERFORMANCE - 1983 TO 1986

In FY84, the agency established an aggressive management agenda--improved service delivery for clients, lower error rates, improved recipient grant levels, an employment and training program focusing on long-term employment, assistance for the homeless, cost containment--designed to improve all aspects of agency performance. Using resources provided by the legislature in these administrative accounts, the Department has experienced considerable success in achieving these goals. Examples include:

- o Fewer staff. As the graph below shows, the number of positions in the agency has declined during the FY84 to FY86 period. Because of improved personnel management and efforts designed to contain administrative costs, the Department will have 150 fewer FTE positions in FY87 than it had in FY84.

Staff Reductions FY84 to FY86



Despite having fewer staff, agency performance across a broad range of indicators has improved.

- o Lower error rates. The current error rates of 3.0% in AFDC and 1.2% in Medicaid are the lowest in the history of the Department. These achievements are the result of the Department's comprehensive error reduction strategy, which included, increasing the number of direct service workers assigned to the local offices, and improving working conditions in the local offices. These activities are funded primarily out of the Local Office Operations account (4400-0950).
- o 23,000 ET Placements, Saving the Commonwealth \$69 million. Since the beginning of the Employment and Training Program (ET) in October 1983, more than 23,000 AFDC and GR recipients have been placed in full or part-time jobs. The efforts of ET workers in the Department's local offices, funded out of the Local Office Operations account, (4400-0950) and the Employment and Training account (4407-1000) have saved the Commonwealth more than \$69 million to date.
- o Child Support Collections Are Up. Child Support workers, funded out of the Child Support Enforcement account, (4400-1004) have increased child support collections by 12.5% during the FY83 to FY85 period, from \$40.1 million to \$45.1 million. In FY86, projected collections are \$50 million.
- o Finance Collections Are Up. During the period FY83 to FY85, Finance collections have increased from \$19 million to \$36.8 million, and will be \$40 million or more in FY86. These increases are due in part to increased administrative resources - staff, computer support -- funded out of the Management and Support account (4400-1000).
- o Employee Morale Is Up. Morale among the workforce, especially among the direct service field staff, has improved significantly. The best measure of this is that turnover among the direct service staff has declined by more than 30% from FY83 levels. The ability of the agency to provide for workers, clean, safe, professional work environments, modern office equipment, and salaries commensurate with increasing levels of responsibility and accountability has resulted in the retention of a capable, experienced workforce. Adequate funding in the Management and Support account (4400-1000) and in other administrative accounts has contributed to increasing levels of performance since FY83.
- o Medicaid Savings Are Up. Between FY84 and FY86, Medicaid savings have increased from \$106 million to \$220 million, and will total \$262 million in FY87.

Thus, with resources from the legislature, the Department has been able to make significant progress in these and other areas described in various accounts in this section of the narrative.

In FY87, building on the base of the dramatic improvements in performance during the FY83 to FY86 period, the Department is proposing initiatives designed to improve further agency performance, including maintaining low error rates, reaching our ET placement goal of 10,000, and achieving an additional \$70 million in new savings and revenue.

In the narratives which follow, the agency's FY87 direct service and management initiatives are described in detail. Briefly, this section contains:

- o A Special Report on Error Reduction, which explains the error reduction efforts which have resulted in the lowest rates in the history of the Department.
- o The Local Office Operations account (4400-0950), in which efforts to maintain low error rates, improve service delivery, and prepare for MPACS implementation are described.
- o The Management and Support account (4400-1000), which supports the core agency management activities and increased Finance collections, and in FY87, includes the consolidation of the Contracts Operation account (4400-0900) to better manage and coordinate contractual services.
- o The Medicaid Management account (4400-1003), which funds a large portion of the personnel and support costs associated with managing the Medicaid program and the Medicaid savings agenda.
- o The Medicaid Management Information System account, MMIS (4400-1012), which funds the costs of operating the Department's sophisticated Medicaid Management Information System, which saved \$56 million in its first year of operation.
- o The Child Support Enforcement account (4400-1004), which funds the child support staff and activities designed to achieve \$56.3 million in child support collections in FY87; and the Child Support Systems account (4400-1014), a federal reimbursement account, which provides funding for special systems projects which support collection efforts.
- o The Systems account (4400-1010), which provides funding for the core day-to-day service activities of the Department's System Division, including: maintenance and enhancement of the Department's current eligibility system; on-going office automation projects; and technical support for on-going agency activities.
- o The Massachusetts Public Assistance Control System, or MPACS (4400-1016). In FY87, the Department will implement statewide its new automated eligibility determination and benefit issuance system, MPACS. Progress to-date and critical FY86 and FY87 tasks are explained, as are the benefits to be derived from the fully implemented system.

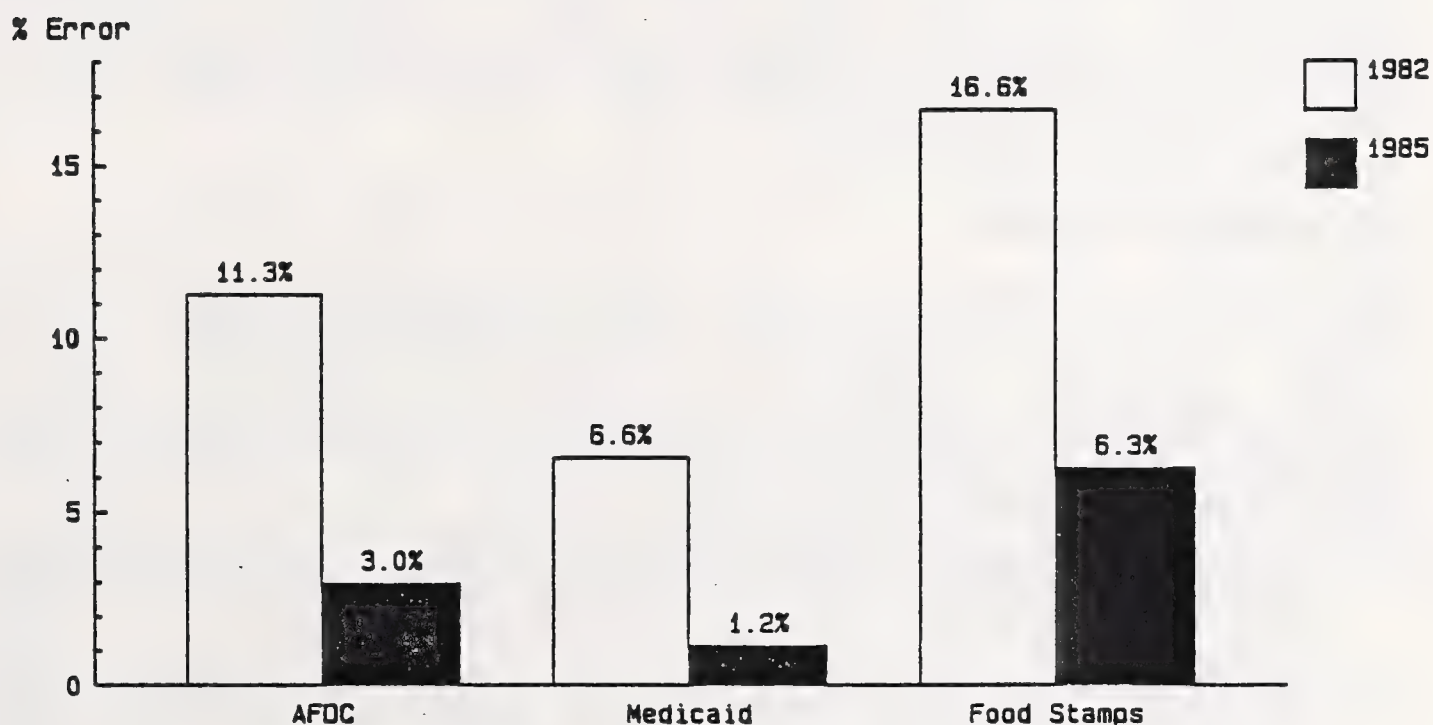
- o The Training account (4400-1035). With MPACS implementation in FY87, the role of training becomes critically important. This narrative explains in detail the training required to implement fully MPACS, to improve service delivery to clients, and to upgrade the skills of the entire staff.

SPECIAL REPORT ON ERROR REDUCTION

One of the agency's most important management objectives is to accurately deliver benefits and services to the Commonwealth's needy families and individuals. Errors in this process can result in inaccurate payments, misspent funds, and potential federal sanctions against the Department. In addition, high program error rates can lead to a loss of public confidence in the Department's ability to manage public funds. Welfare benefit programs are too often thought of as mismanaged efforts, and this common misconception often hinders efforts to improve services for the Commonwealth's needy poor citizens. To dispel this belief, and to help control expenditure growth, the Welfare Department, with the assistance of the Massachusetts legislature, has undertaken an aggressive management effort to reduce error rates. Over the last three years, these efforts have:

- o reduced the AFDC error rate from 11.3% in late 1982 to 3.0% in 1985, the Commonwealth's lowest rate ever;
- o reduced the Medicaid error rate from 6.6% in late 1982 to 1.2% in 1985, the lowest rate ever; and
- o reduced the Food Stamp error rate from 16.6% in late 1982 to 6.3% in 1985, the lowest rate ever.

**Welfare Error Rates
1982 v. 1985**



WHAT IS ERROR?

Every year the Department's Quality Control (QC) unit reviews a random sample of approximately 1,200 AFDC cases, 1,200 Food Stamp cases, and 1,800 Medicaid cases to determine the number, amount, and causes of erroneous payments, as well as the error rate itself. The error rate is determined in three steps. First, the Department estimates the error rate based on its sampling. Next, federal auditors review a portion of the Department's sample to validate the accuracy of the Department's work and make their own estimate of the error rate. Finally, any discrepancies between the state and federal estimates are reconciled by statistical analysis, and an official error rate is produced.

The error rate can be defined and measured in several different ways. It can be measured as a percentage of total cases in error (case error rate) or as a percentage of total expenditures made in error (payment error rate). The payment error rate gives greater weight to cases with mistakes that cost more, weighing cases on the basis of dollar errors. However, even the payment error rate is not a direct indication of misspent dollars. Some errors are known as "paper errors" because, when corrected, they do not reduce expenditures. For example, federal policy requires that each AFDC recipient over the age of three months have a Social Security number. When money is paid to a recipient without a Social Security number, it is an error and the total amount of aid paid to the recipient that month is considered in error. Since the error will be corrected as soon as the recipient gets a Social Security number, elimination of the error does not result in savings. Although the payment error rate overstates the amount that could be saved by reducing error it is nonetheless the primary measure of the Department's ability to accurately deliver benefits.

WHY ERROR IS A PROBLEM

There are four serious costs to error: the potential loss of federal reimbursement if a program's error rate exceeds the federally specified target; the cost of payments that the Department should not have made; the loss of public confidence in the Department's ability to fairly and accurately deliver benefits; and the hardship recipients may encounter if they receive less than their full grants.

- o Federal Sanctions. Congress sets error rate targets for the major assistance programs that the federal government participates in funding (AFDC, Medicaid, and Food Stamps). States that exceed specified error reduction targets can be sanctioned by the federal government through the withholding of federal matching funds. For each percentage point in excess of the target states may be sanctioned a proportion of the funds they receive from the federal government for the program in question. The current federal targets, and potential sanction amounts for Massachusetts are shown below.

Program	Federal Error Targets	Sanction for each Percentage Point Above Target
AFDC	3%	\$2.2 million/year
Medicaid	3%	\$5.5 million/year
Food Stamps	5%	\$1.2 million/year

- o Misspending. When the Department pays benefits to ineligible cases, or overpays eligible recipients, misspending occurs. Funds are spent which could otherwise be used to help truly needy clients. Although the payment error rate overstates the actual proportion of inappropriate spending because it includes paper errors, the total is still considerable. One percentage point of real error in the AFDC program would amount to more than \$4 million in misspending.
- o Public Confidence. High error rates also erode public trust in the Department and the needs of the clients it serves, reinforcing inaccurate stereotypes about welfare recipients.

ERROR RATE PERFORMANCE AND STRATEGY, 1983 - 1985

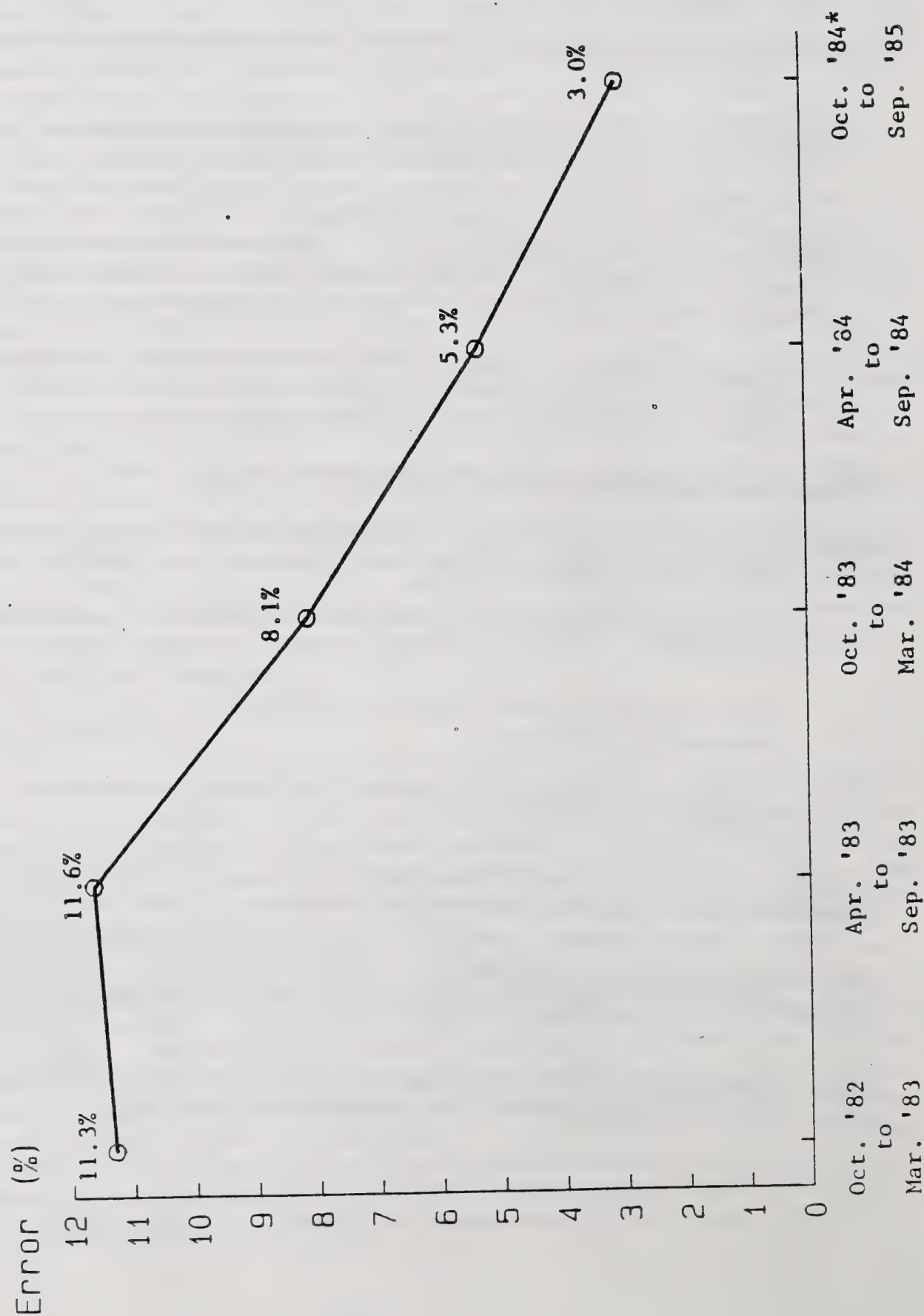
As noted above, the Department's concerted effort to reduce program error rates has met with remarkable success. Since late 1982:

- o the AFDC error has declined by more than 8 percentage points to 3.0%;
- o the Medicaid error rate has declined by more than 5 percentage points to 1.2%; and
- o the Food Stamp error rate has declined by more than 10 percentage points to 6.3%.

In all three programs, the 1985 error rates noted above are the Commonwealth's lowest ever, and in the case of AFDC and Medicaid, are at or below federal target levels. If the error rates in AFDC, Medicaid, and Food Stamps had remained at their 1982 levels, the Department would have paid out an additional \$115 million in inappropriate benefits in FY85.

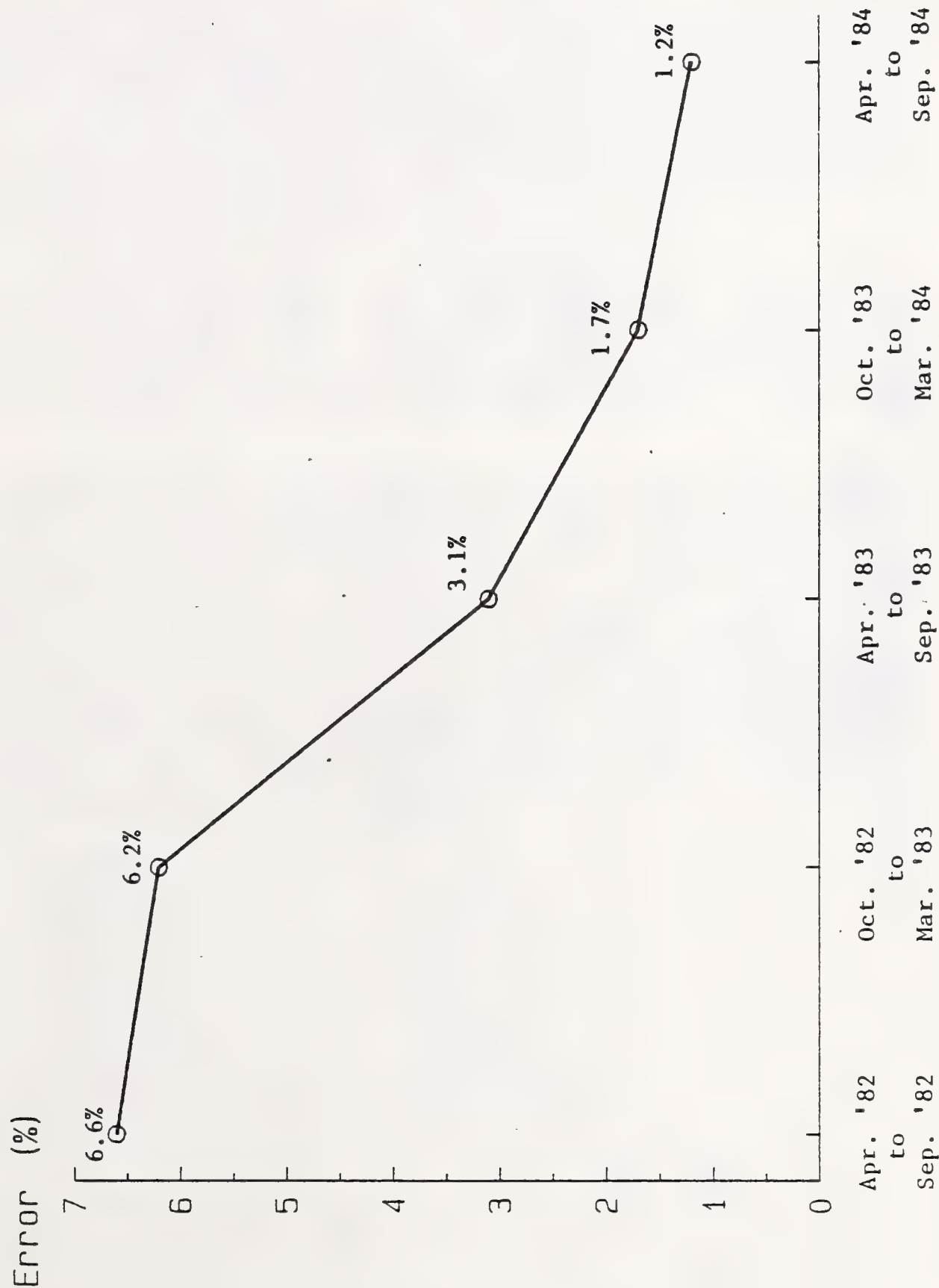
Error rates for each of the Department's principal programs over the past three years are depicted in the graphs which follow.

AFDC Error Rate 1982 to 1985

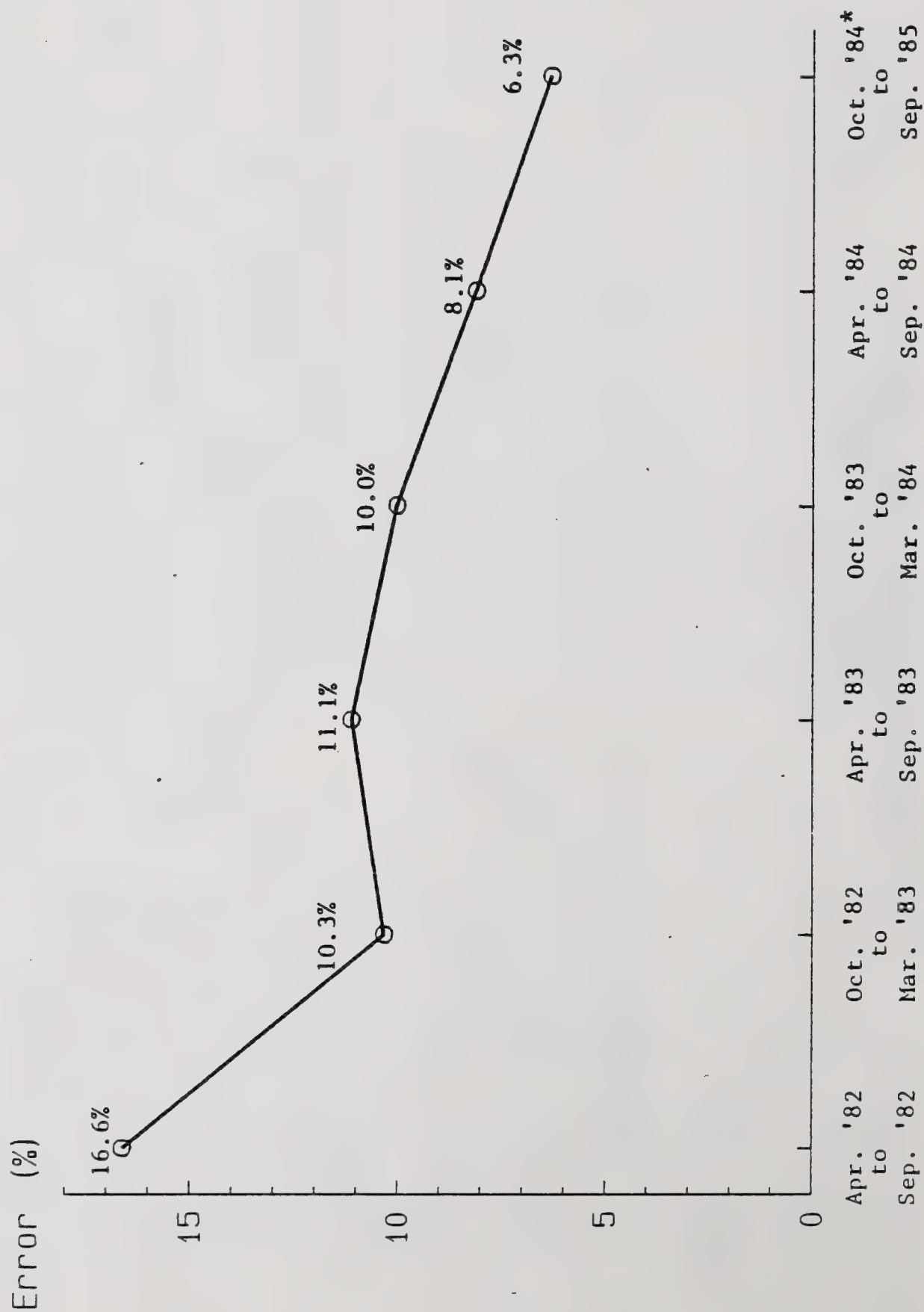


* Error rate sampling conducted on a yearly basis beginning 10/84.

Medicaid Error Rate 1982 to 1984



Food Stamp Error Rate 1982 to 1985



* Error rate sampling conducted on a yearly basis beginning 10/84.

In achieving the dramatic reductions noted above, the Department set for itself a comprehensive error reduction plan designed to produce immediate error rate reductions, while laying the groundwork for further improvements. The six principal components of this plan are described below.

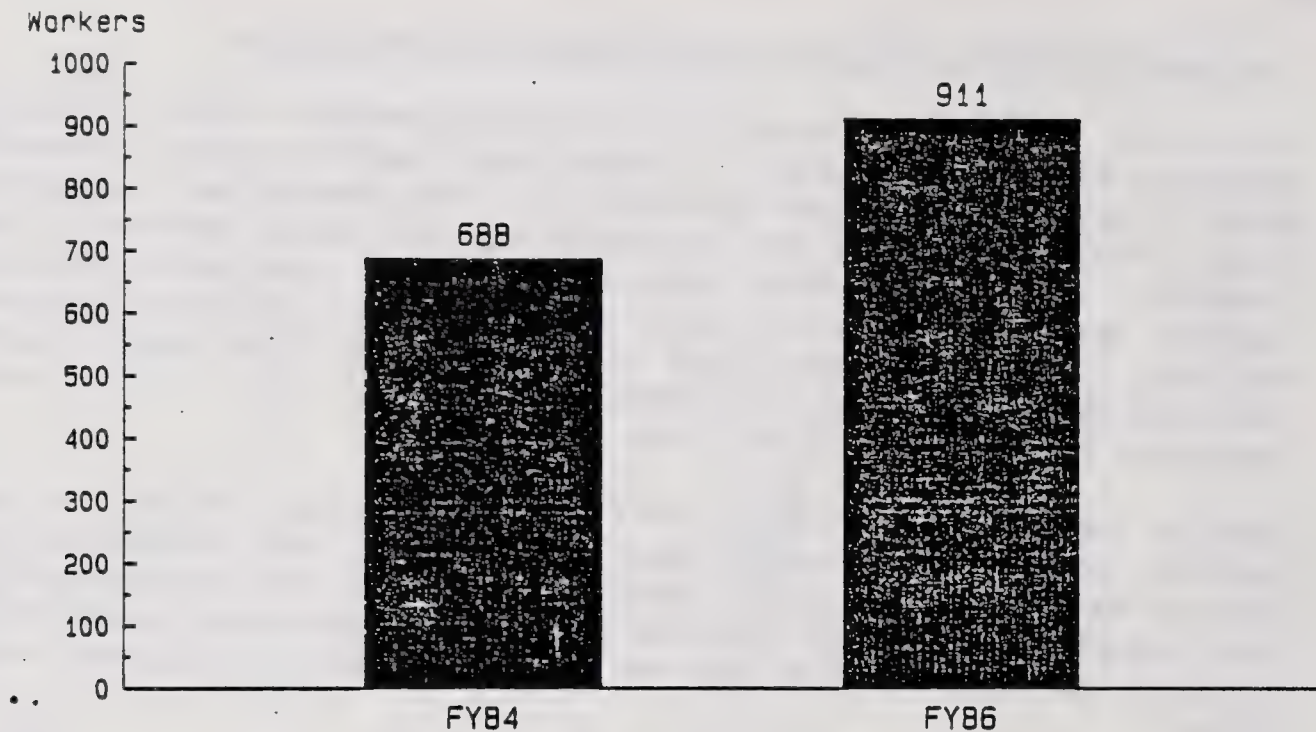
A. Increased Staffing and Lower Caseload to Worker Ratios.

The most important factor in the Department's error reduction strategy is its field staff. Field staff maintain all information about clients, communicate directly with recipients, and are responsible for carrying out and implementing any error reduction plan. Likewise, a difficult work environment and a constantly changing, complex set of eligibility rules increases the likelihood of errors by field staff. In recognition of the key role field staff play in reducing the error rate, the Department's first step was to provide immediate relief to local offices.

Ongoing Payments Unit (OPU) staff are responsible for all critical ongoing client assistance, case maintenance, and redetermination activities. Prior to FY85, caseload-to-worker ratios were so high that almost all of their time was spent delivering basic services and emergency aid, and little time on activities related to error reduction.

In response to this problem, the Department increased the number of case-carrying workers responsible for cash assistance programs (AFDC, GR, and Refugee) and Medicaid cases from less than 700 in FY84 to over 900 in FY86. As a result, the average number of cases per worker has dropped from 210 in FY84 to 170 in FY86. These staffing increases were made possible through increased staffing levels, authorized by the administration and the legislature, redeployment of central office staff to the field, and better management of vacancies and the hiring process. Prior to this new hiring process, offices often had to wait 6 to 8 months before vacancies were filled, workers were trained, and finally sent to a local office. Now offices receive replacements in 6 to 8 weeks.

**Increase in On-Going Payment Unit Workers
AFDC/GA/RAP/MA
FY84 - FY86**



B. "Workload" to "Caseload" Transition

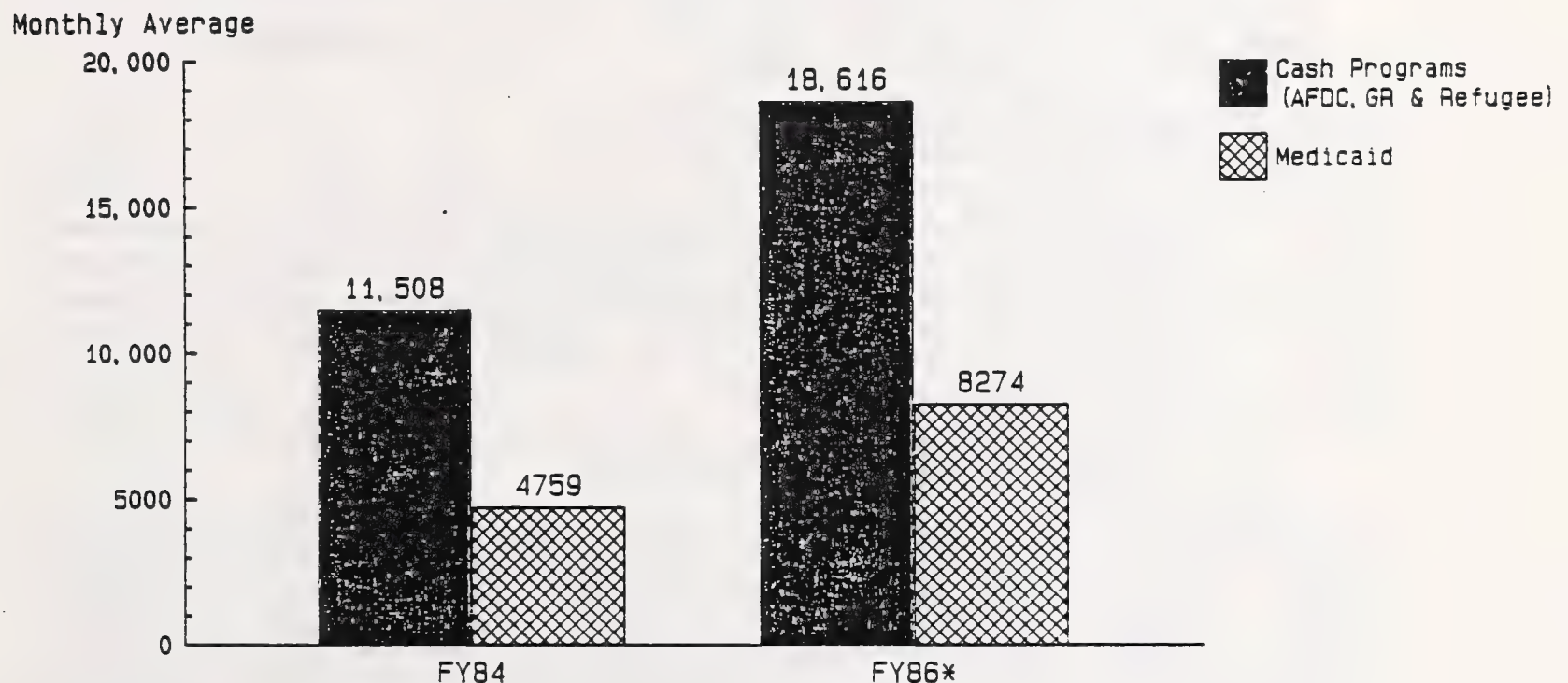
In addition to reducing the number of cases per worker, the Department changed the system by which cases are assigned to workers to one in which workers have ongoing responsibility for particular cases, i.e., a caseload system. This transition was made during FY84. Previously, under the workload system, as an individual action needed to be taken on a particular case, the action was performed by whatever worker was available. This led to fragmented attention to cases, with no one person being responsible for a case. Under the caseload system, clients have access to a consistent source of assistance and workers have responsibility for maintaining accurate information on a specified set of cases.

C. Redeterminations

The core of the Department's error rate strategy is increased communication with clients. Three-quarters of error is client-caused error, or due to information not known to workers. The most important way of increasing the chance of getting this information about the changing circumstances of families is to increase the number of face-to-face eligibility interviews (i.e., redeterminations) that clients have with workers.

As shown in the following graph, the number of redeterminations completed by the Department's workers each month has increased dramatically. For example, in FY84, the Department performed, on average, 11,500 redeterminations for cash assistance cases each month. In FY86, this has increased to more than 18,500. Similarly, the number of Medicaid redeterminations has increased from less than 4,800 per month in FY84 to almost 8,300 in FY86. This increase has meant a decrease in the average time cases wait between redeterminations from over 10 months for cash assistance cases in FY84 to under 6 months in FY86. The time between Medicaid redeterminations has dropped from more than 14 months in FY84 to just over 7 months in FY86. More redeterminations and a lower turnover rate mean that workers are more likely to examine cases in error, and are likely to examine them sooner.

**Average Monthly Redeterminations
Cash and Medical Programs
FY84 - FY86***



*first five months

D. Increased Accountability

A principal management tool in the strategy to reduce the error rate has been increased accountability at the local office level for the performance in that office. Towards that end, in addition to moving to a caseload system for workers, the Department has:

- o Under the direction of the Commissioner, focused senior managers' attention on this problem in weekly meetings to review progress on the Department's detailed error reduction plan, using QC results uncovered by the Error Rate Review Committee;
- o Redefined the supervisor's role from that of someone whose principal responsibility was reviewing and monitoring the number of actions performed to one whose primary responsibility is solving the error problem in an individual local office by reviewing cases and suggesting ways to correct problems which are likely to cause error; and
- o Developed a monthly local office error rate score which measures the performance of individual offices and can be used to identify offices with high error and measure the effectiveness of their corrective action plans.

E. Better Work Environment in Local Offices

Together with increasing the responsibility of local office staff, the Department also freed them to concentrate on the difficult error rate problem by reducing the number of cases per worker and by streamlining the work environment in two important respects:

- o 50 Forms Eliminated

Due to the complicated and varying federal and state regulations in the more than one dozen programs the Department administers, workers must be familiar with nearly 100 forms. In order to reduce this burden on workers, more than 50 forms have been eliminated, and more have been shortened, simplified, and improved.

- o Upgradings for Local Office Staff

Employee morale and motivation are critical to the task of reorienting the energies of the Department's local office staff towards lowering the error rate. Effective January 1, 1985, the Department upgraded basic field staff positions, as a reward for the successful efforts of field staff to date and as a strong motivator for continued performance. In addition, these upgradings address the difficult problem of high staff turnover that local offices face in reducing the error rate.

o Renovation and Relocation of Offices

In addition to upgrading basic field staff positions, the Department has acted to improve workers' physical surroundings. During FY84 and FY85, the Department renovated or relocated 26 of its 64 local offices. In FY86, the Department plans to renovate or relocate an additional 16 offices. In just three years, half of all the Department's local offices facilities will have been improved.

F. Better Error Reduction Tools

A final important component in the Department's error reduction strategy is improved tools for local offices and the central office to identify error. These tools include:

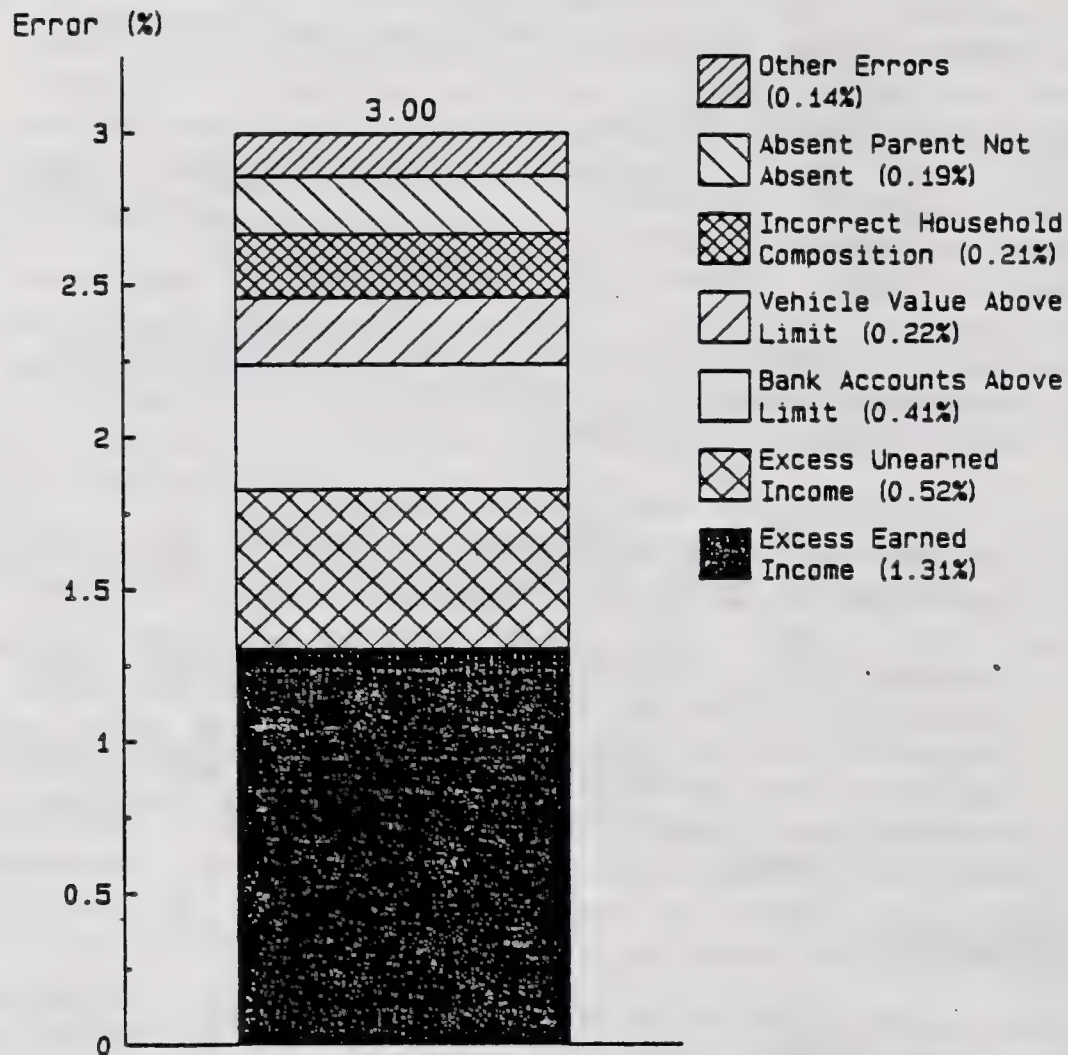
- o Improved computer matching with the Departments of Revenue and Employment Security, the Registry of Motor Vehicles, and banks and savings institutions;
- o A Prioritized Activities Listing (PAL) for local office workers which identifies and prioritizes all activities to be performed on cases, by how error-prone they are; and
- o Special error reduction projects, directed against specific cases identified as being especially error-prone. Two such projects resulted in locating and closing more than 500 cases in error, and correcting 1,200 cases in error over a period of two months. These are errors which were previously unknown to the Department.

FURTHER REDUCTIONS

Lowering the error rate is perhaps the most difficult management problem facing the Department. Changing federal and state eligibility and payment policies, combined with fluctuating circumstances in the lives of recipients, make it nearly impossible to deliver precisely correct payment amounts at all times. Moreover, the problem is further complicated by the fact that most error -- three-quarters in the case of AFDC -- is caused by clients. That is, most error is caused not by the Department's misapplication of policy or failure to act on known information but because clients fail, either purposely or through misunderstanding, to report changes in their circumstances.

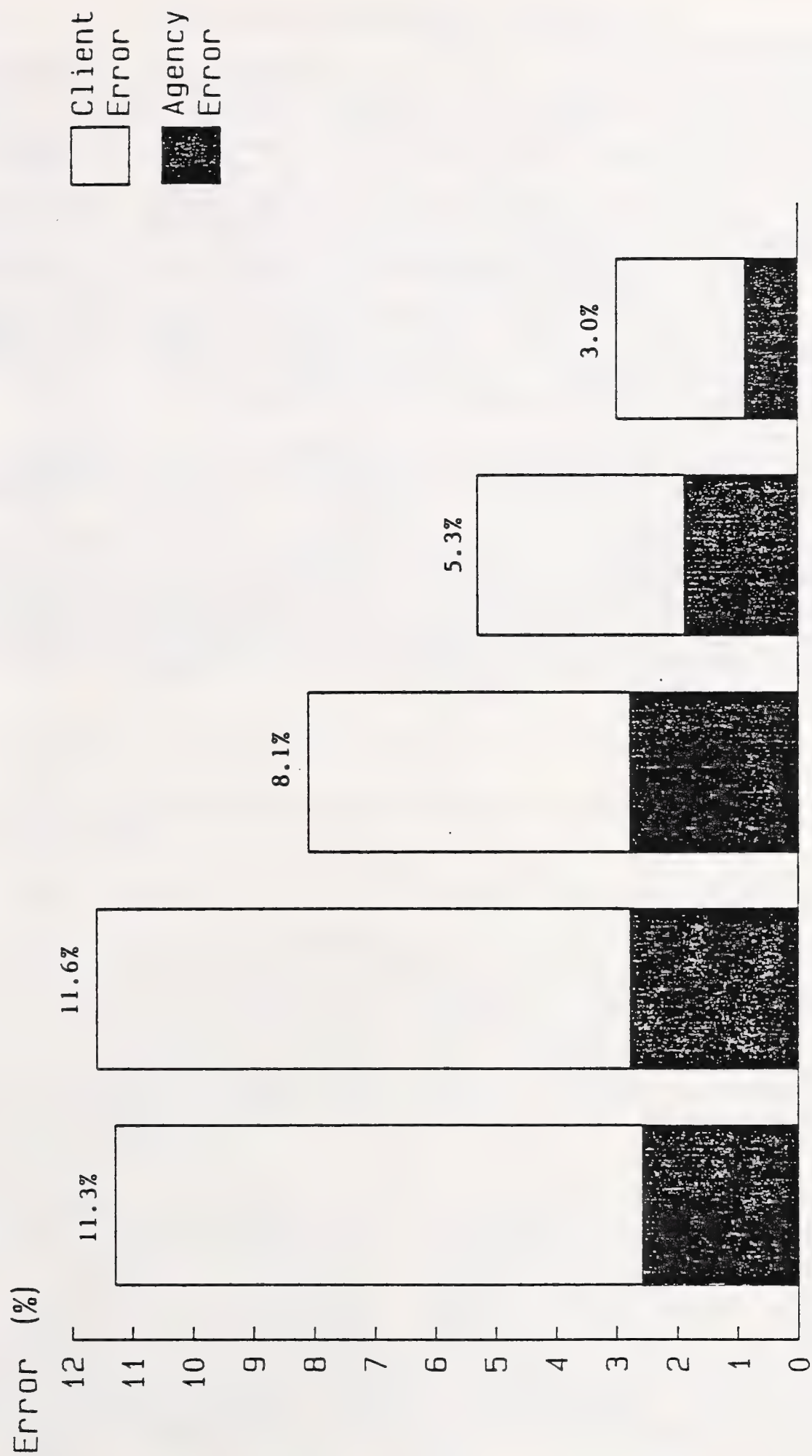
The following chart presents a detailed breakdown of the components of the AFDC error rate for the most recent QC period for which data is available, indicating the relative contribution of the various types of error to the error rate. The most common cause of AFDC error is undisclosed earned income. Not only is it the most frequent source of error (two-fifths of error during the last period), but this error is primarily caused by clients. Other major components of error which are primarily client caused include: unreported unearned income, undisclosed bank accounts, unreported vehicles, and the non-absence of a second parent.

Components of the AFDC Error Rate October 1984 - September 1985



The chart which follows shows more clearly the proportion of error caused by the Department versus that caused by clients. Over time, the proportion of error due to the Department has declined, and is currently less than 1 percentage point. This distinction between client and agency-caused error is important because each type of error requires different corrective action. When a program has a high percentage of client-caused error, remedial action must focus on improved disclosure, verification, and tracking of information. To this end, the Department has increased its redetermination activity and improved its computer matches with other organizations.

Client v. Agency Error AFDC 1982 - 1985



FY87 ERROR REDUCTION AGENDA -- MPACS

A significant stumbling block in maintaining low error rates and further reducing error is the Department's current computer system. Many error reduction efforts require the use of the computer, including matching with other agencies and banks, developing error-prone profiles and selecting cases to be redetermined in a given month. The Department's normal business, maintaining eligibility information and sending out benefits to more than half a million clients each month, would not be possible without a computer system. The Department's current system was designed around 1970 and in the intervening years has become outmoded and is held together in patchwork style. Because the system is outmoded, it not only severely hampers error reduction initiatives, but it makes the Department's day to day business very difficult.

Because of these limitations, the Department has been designing a new system, MPACS, as a replacement. MPACS will enable the Department to keep more accurate and timely eligibility information, significantly reduce time-consuming paperwork, and improve the Department's ability to track changes in client circumstances. MPACS will give the Department's field workers both the time and the tools necessary to reduce errors. With the implementation of MPACS, slated to begin in July 1986, the Department believes that it will be able to reduce error rates below federal target levels and maintain them at low levels.

LOCAL OFFICE OPERATIONS (4400-0950)

	<u>FY84*</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures	--	\$59,645,000	\$71,319,000	\$74,213,433

INTRODUCTION - THE IMPORTANCE OF LOCAL OFFICE OPERATIONS

The Department's field activities are funded primarily from the Local Office Operations account. While the costs of actual benefits are funded through program accounts, the delivery of those benefits is funded through administrative accounts, of which Local Office Operations is the largest. Because administrative functions in most instances tend to overlap programs, a local office worker whose salary is funded by this account may participate in the delivery of several programs and services.

Prior to FY85, field activities were funded primarily out of the Management and Support account (4400-1000). The legislature separated field office operations from the central administrative account in FY85. This move accurately represents agency operations and targets funds more directly toward those activities which the Department has defined as crucial:

- o lower error rates in all categories of assistance;
- o service delivery which offers clients realistic alternatives to poverty; and
- o working conditions that are conducive to quality performance.

Through this account, the Department will administer more than \$1.9 billion in AFDC, GR, Food Stamps, SSI and Medicaid benefits to more than half a million clients across the Commonwealth each month. While the Department's field activities are directed from the central office through the development of goals and procedures, the Local Office Operations account provides the funding for the salaries of the Department's field staff and for the support costs directly associated with its field operation.

The central task in the administration and delivery of welfare benefits and services is that of eligibility determination, or the decision as to whether an applicant meets or a recipient continues to meet the eligibility criteria for various programs of assistance. It is the responsibility of the eligibility staff in the local offices to accurately determine and redetermine client eligibility. Additionally, local office direct service workers maintain the case files of recipients and provide client services. Clearly, the extent to which key agency goals are achieved depends critically on staff performance in the field.

* Local Office Operations were funded in the Management and Support account (4400-1000) in FY84.

Volume of Services

In FY87, each day local office direct service staff will:

- o determine the initial eligibility of 7,000 AFDC, GR, and Refugee Assistance applicants.
- o redetermine the eligibility of 19,000 AFDC, GR, and Refugee Assistance recipients.
- o determine the initial eligibility of 4,800 Medicaid applicants.
- o redetermine the eligibility of 7,500 Medicaid recipients.
- o perform case maintenance activities on 12,000 cases.
- o determine the initial eligibility of 7,100 non-public assistance Food Stamp applicants.
- o provide Emergency Assistance to more than 1,200 clients.

Additionally, in support of other Department programs, local office direct service staff each day:

- o make 3,000 referrals to the Department's Employment and Training program.
- o refer 6,400 AFDC parents to the Child Support Enforcement Unit.
- o refer 8,620 children of AFDC and Medicaid recipients to the Project Good Health program.

To a significant extent, the Department's performance in the field is determined by the performance of the direct service staff. As the source of funding for the Department's field operations, the Local Office Operations account funds the number of staff that monitor and review the eligibility of families receiving cash assistance, medical assistance, and other benefits and services offered by the Department. Additionally, the work environment, which directly affects worker morale and thus productivity, is critically affected by the level of funding in this account. Therefore, an adequate investment in the Local Office Operations account will pay for itself many times over in reduced erroneous payments and improved service delivery for clients.

IMPROVED PRODUCTIVITY: LOCAL OFFICE PERFORMANCE, 1983 - 1986

Over the past three years, the Department's field operations have undergone a major transformation. In the past, due both to management and resource problems, the Department was unable to provide the staff and support resources required to accurately deliver benefits and services to needy, eligible clients.

The Problems

In FY84, understanding fully the extent to which agency performance is determined by the performance of individual workers in the field, the Department identified the following factors as contributing to poor performance:

- o too few direct service staff assigned to the local offices resulting in unmanageable caseloads for individual workers.
- o the inability of the agency to hold direct service workers accountable for performance.
- o poor working conditions in many of the local offices.
- o high turnover rates among direct service workers.

The combined effect of these problems was:

- o high error rates, especially in AFDC
- o service delivery which failed to respond to client circumstances and needs, and failed to provide clients with realistic alternatives to poverty.

The Solutions

To overcome these problems, in FY84, the Department directed its efforts towards improved worker productivity in the field. These efforts sought to:

- o increase the number of qualified direct service workers assigned to the local offices, bringing about more manageable caseloads for individual workers.
- o increase worker accountability
- o provide work environments conducive to quality performance.
- o increase employee morale and motivation.

To date, these initiatives have achieved considerable success. Performance across a broad range of staff-sensitive indicators has improved substantially. Specifically:

- o Error Rates are Down. The AFDC error rate for the most recent period ending July, 1985 stands at 3.0%, down from a high of 11.6% in 1983. The current error rate in Medicaid is 1.2%. Both of these rates are the lowest in the history of the Department.
- o More Frequent Redeterminations. The number of AFDC cases redetermined in 6 months or less has increased by more than 90%.

- o Turnover Rates are Down. The AFDC redetermination turnover rate or the length of time between redeterminations, has declined from 10.1 months in July 1984, to 5.2 months in October 1985.
- o Caseload to Worker Ratios are Down. The caseload to worker ratios for on-going AFDC and Medicaid cases have declined significantly since FY84. In FY86, the average AFDC case-to-worker ratio stood at 170:1, down from 210:1, and the Medicaid ratio had declined from 500:1 to 375:1.
- o Better Work Environment. During FY84 and FY85, 26 of the Departments local offices were renovated or relocated to better space. In FY86, the Department plans to upgrade 16 of its local offices.
- o ET Placements. ET workers have helped place over 23,000 clients in jobs since October 1983, providing a real alternative to public assistance.
- o Increased Employee Morale and Motivation. Through position upgrading, employee services and performance recognition, and training for direct service workers and supervisors, the Department has reduced local office staff turnover by 30%.

A. Increased Field Staffing and Lower Caseloads

In FY84, based upon detailed, office by office analysis of staffing patterns and caseloads by category of assistance, comparative analysis of other large industrialized states with lower error rates than Massachusetts, and a detailed examination of the work performed by local office on-going staff, it was determined that:

- o the best way to reduce error to federally mandated levels was to more frequently redetermine the eligibility of the various caseloads.
- o a critical error reduction factor is the caseload-to-worker ratio.
- o the only remedy substantial enough to reduce the redetermination rate to the Department's goal of six months for AFDC, GR, and Refugee Assistance and nine months for Medicaid was to increase the number of staff in the on-going payment units in the local offices, while also increasing accountability.

In FY84, for example, while the Department maintained AFDC, GR, and Refugee Assistance case-to-worker ratios of between 210:1 and 220:1, New York City was staffing at 160 cases per worker. The Massachusetts error rate was 10 to 11%, while New York's was as low as 5 to 6%.

In the past, due to high caseloads, workers spent as much as 70% of their time responding to clients' requests for services and other activities unrelated to the error rate. These activities are critical and must be completed, but do not result in error reduction. To allow workers time to complete error-related activities and to continue to serve clients, it was clear that more realistic case to worker ratios needed to be established.

In negotiation with the labor union, local 509, S.E.I.U., it was determined and incorporated in a collective bargaining agreement that on-going caseloads for individual workers would be maintained at a maximum of 191 for assistance payments programs and 490 for Medicaid. On the basis of an analysis which took into account vacancy factors, turnover rates, vacations, training, and the fact that caseloads are distributed unevenly across local offices, it was further determined that caseload staffing goals of 150:1 in AFDC and 375:1 in Medicaid were required in local offices to ensure that individual workers did not go above 191 AFDC cases and 490 Medicaid cases.

To reduce caseloads for individual workers to more manageable levels, the Department increased the number of workers assigned to the on-going payment units in the local offices. The introduction of more than 200 additional direct service workers has enabled the Department to increase the number of monthly AFDC and MA redeterminations by 62% and 74%, respectively, over FY84 levels. The Department provided those additional workers through a combination of vacancy filling and redeploying staff from the central office.

As the following charts indicate, as the number of direct service workers assigned to the ongoing payment units increased, in turn lowering the caseload to worker ratio, local office workers were able to determine more cases per month. As the redetermination turnover rate declined, so did the error rates.

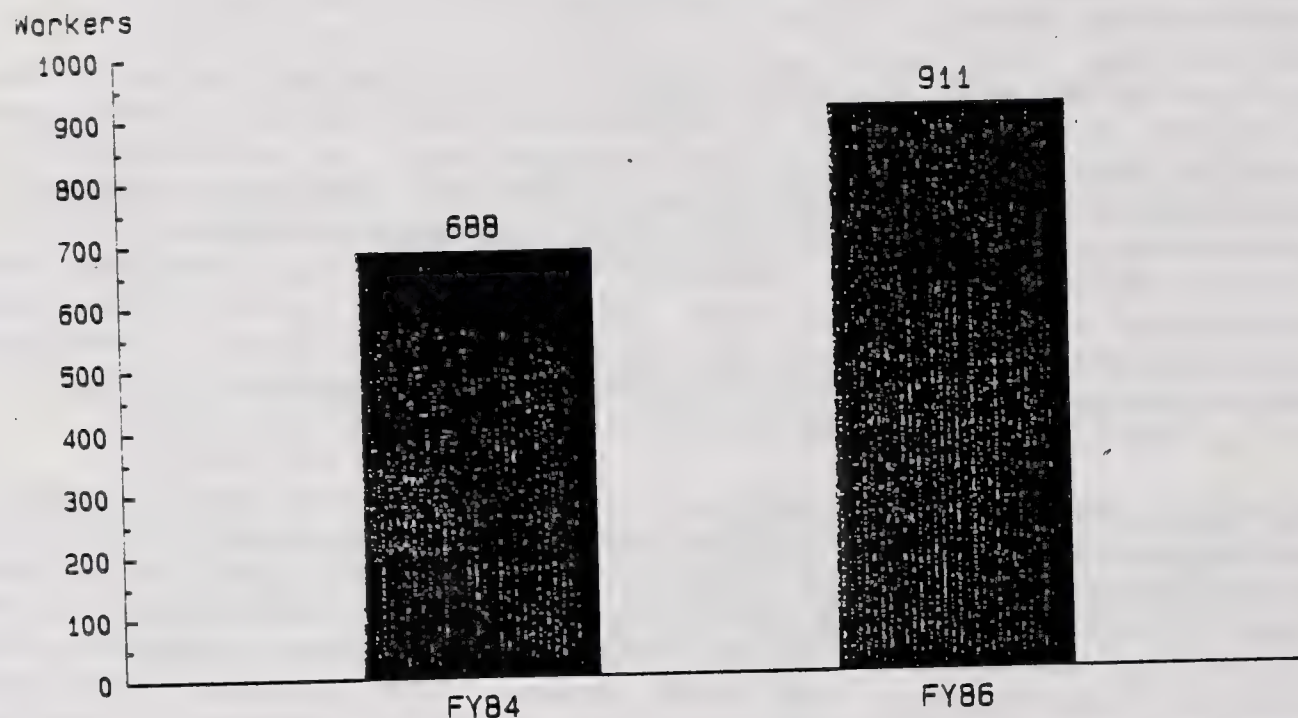
In FY85, to maintain lower case to worker ratios the Department began to maintain a pool of workers in training at all times. The maintenance of a pool of workers in training allows the Department to respond rapidly to turnover, vacations, and extended worker absences, and to maintain manageable case to worker ratios. The time required to fill a vacancy now ranges from 1 to 14 days, down from 6 to 9 months in FY83.

B. Increased Accountability

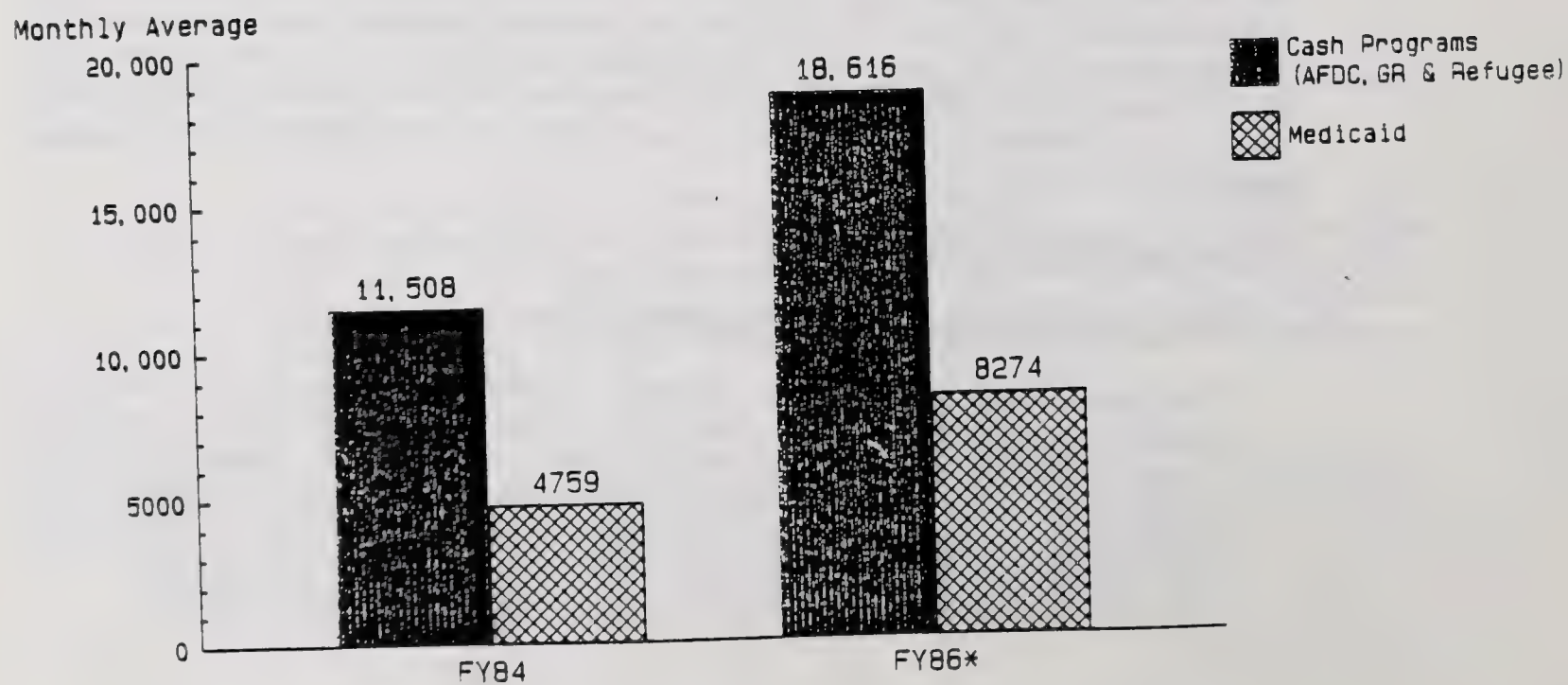
o Workload to Caseload Management System

The workload management system, introduced in FY82, assigned cases to workers on the basis of worker availability. That is, like in a bank, as work in a local office was generated, the local office program director would assign the case to the worker and supervisory unit that was free at the moment. If, however, one week later the same case required additional attention it could very well be assigned to a different worker within a

Increase in On-Going Payment Unit Workers AFDC/GR/RRP/MA FY84 - FY86

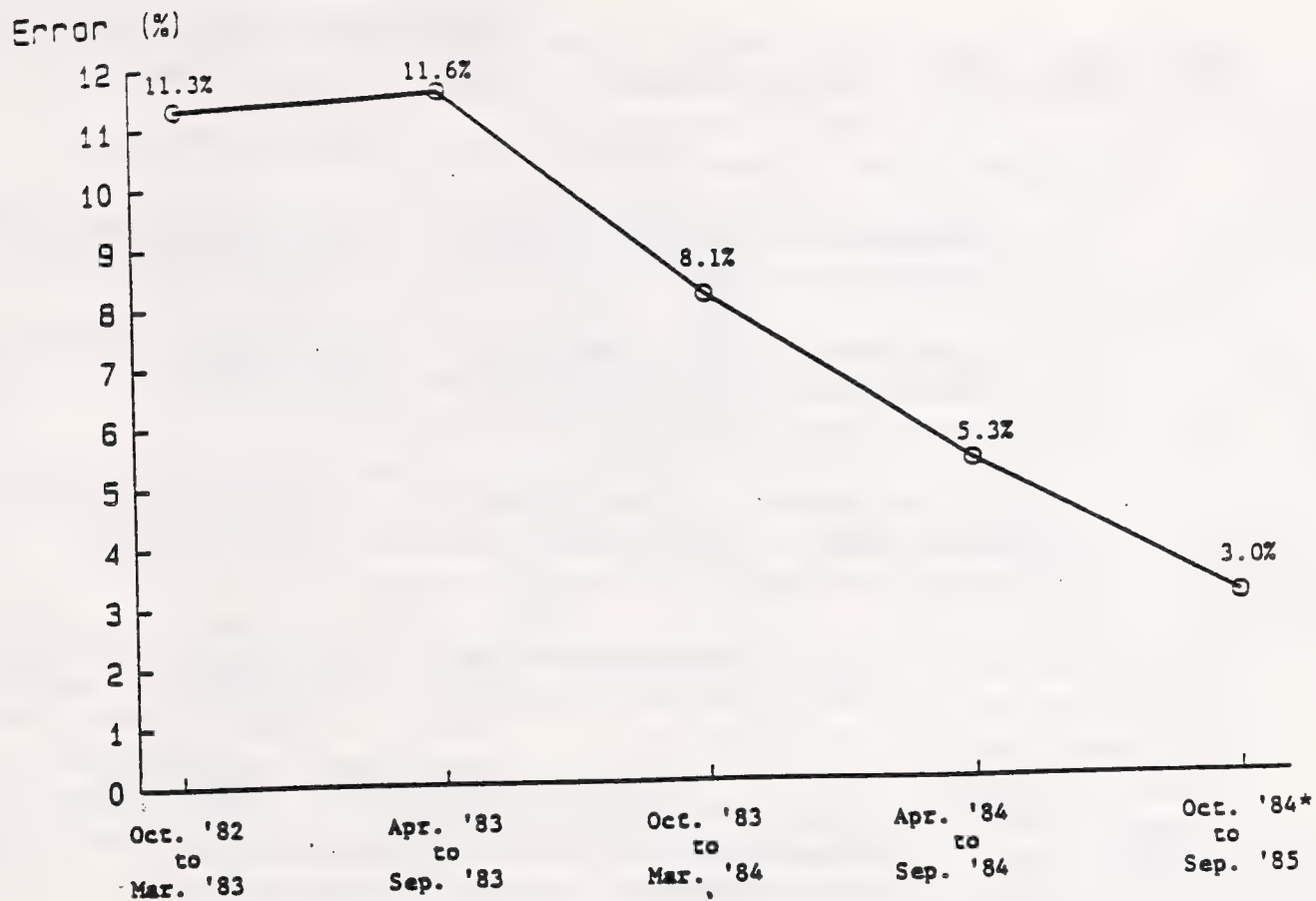


Average Monthly Redeterminations Cash and Medical Programs FY84 - FY86*



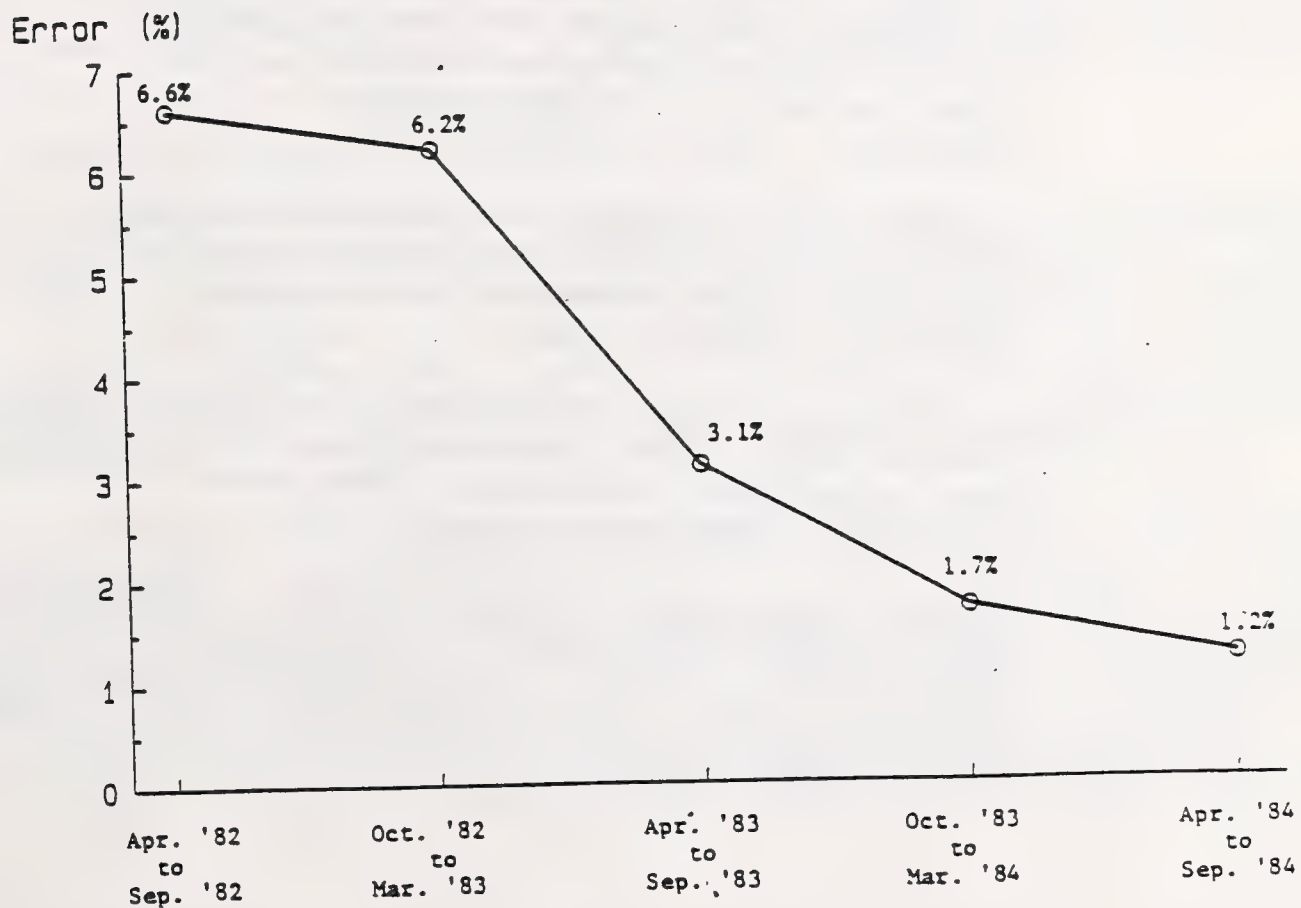
*first five months

AFDC Error Rate 1982 to 1985



* Error rate sampling conducted on a yearly basis beginning 10/84.

Medicaid Error Rate 1982 to 1984



different supervisory unit. The ramifications of such a work assignment system were problematic. Under such a system:

- workers do not become familiar with particular cases;
- it was impossible for one worker to continue following one case, causing a lack of continuity in case maintenance;
- psychologically, there was little reason for a worker to take pride in his or her work in that no particular case could be claimed by any one worker;
- it was difficult to establish or maintain standards of accountability or performance because errors could not be attributed to particular workers.

Additionally, workload management resulted in the inequitable distribution of work in that cases were assigned randomly, regardless of difficulty. Some workers received a disproportionate number of family cases while others received a high number of cases involving individuals. This inequity was consistently raised by the union, and contributed to a deteriorating labor/management relationship.

In FY85, the workload system was replaced by the caseload system and individual workers were made responsible for individual cases. The success of this system was immediate:

- increased accountability. With the introduction of the caseload system, errors could be traced directly to individual workers, allowing for local office quality control. Such a system allows for the recognition of outstanding performance and enables the agency to reward those workers who are deserving and to provide training for those workers whose performance is below acceptable standards.
- increased responsiveness. Workers become familiar with the circumstances of particular cases. As a result, they respond to client inquiries more quickly and can provide needed individual attention.
- more accurate case maintenance. As workers became more familiar with a particular case under the caseload system, case maintenance activities became more routine and the likelihood of error was reduced.
- improved the redetermination process. Cases with which workers are familiar due to case maintenance and client contact are easier to redetermine completely and efficiently, thus reducing the likelihood of error and increasing productivity.

o Field Reorganization

To better manage field activities, the Department reorganized the Division of Eligibility Operations by altering the reporting relationship between the field and the central office. In the past, all local office directors reported directly to the Associate Commissioner for Eligibility Operations in the Department's central office. Clearly, the span of control under such a reporting relationship was problematic. Central office manager could not respond effectively to the needs of 69 local offices, given their size and complexity, thereby reducing the extent to which local office directors and staff could be held accountable for performance. In an effort to correct this, local office directors across the state now report to one of six operations managers from the Division of Eligibility Operations, located in the central office. This new reporting relationship has increased the Department's capacity to communicate effectively with the local office staff.

o Supervisory Unit QC Scores

- The transition to the caseload system and the new reporting relationship enabled the Department to better monitor local office performance. To do so, the Department developed a Local Office Quality Control (LOQC) Team. Instead of relying on the federal Quality Control program, which produces a single statewide QC score every six months, the Department's LOQC team monitors local office error rate performance on a monthly basis. Monthly monitoring of local offices' error rate performance enables the Department to devise and implement corrective action plans in those offices that have high monthly error rates. Additionally, as a result of the transition to a caseload system, the LOQC teams can monitor error rate performance by local office supervisory unit.

C. Better Work Environment in Local Offices

For a number of years, the physical condition of the Department's local offices received inadequate upkeep and maintenance. This neglect produced not only a number of serious and dangerous problems -- poor heating and ventilation (one office, Chicopee, had a reported case of Legionnaire's Disease), chipping and peeling paint, unsanitary conditions, overcrowding, poor lighting, rodent infestation -- but also reduced worker morale and productivity.

In FY84 and FY85, therefore, the Department made local office space improvements a management priority. As a result, 26 of the Department's local offices have been renovated or relocated to better space. These renovations have provided local office workers with improved ventilation and air quality, accessibility for handicapped persons, interviewing cubicles, function rooms for data entry and photo ID production, partitions, and redesigned reception areas. As a result of the professional environment these renovations and

relocations have produced, the Department has seen a marked improvement in the attitude, efficiency and productivity of its local office workers.

In FY86, the Department plans to upgrade 16 of its local offices. Most of the renovation work is related to MPACS retrofitting (cabling, electrical wiring) and will be completed during the latter half of FY86. In addition, a number of offices will be relocated to relieve overcrowding and poor heating problems.

When the Department requests renovating space in a local office, it has determined, based on caseload projections and required staffing, that the amount of space is adequate but in need of renovation, and that the renovation can be provided through the negotiation of an affordable rate. In those instances, however, when the Department requests relocating an office, it is because the space, even if renovated, is no longer functionally adequate. The Department's Grove Hall office in Roxbury is a case in point.

Grove Hall is one of the six offices that the Department leases from the city of Boston. Built in 1952, the office provided space for city of Boston welfare workers until 1968, when the Commonwealth assumed responsibility for welfare programs. During the 1950s and into the 1960s the space in the Grove Hall office, given the scope of welfare programs at that time, was more than adequate. In 1986, however, given the tremendous increase in the number of programs administered by the Department over the past 20 years, larger caseloads, and more staff, the space in this office is no longer functionally adequate. For example:

- o During the 1950s the total AFDC caseload in the Grove Hall office was about 520. In December of FY86, the AFDC caseload was 3,375.
- o Since the 1950s, the number of programs administered by the Department, all of which require staff, has increased to include Food Stamps, Child Support, Employment and Training, Project Good Health, Refugee Assistance, Homeless Assistance, Emergency Assistance, and Medicaid.
- o In the past, space constraints were somewhat relieved because workers made home visits and spent much of their time out of the office. The Department no longer does home visits.
- o In addition to the Department's staff, the Grove Hall office houses staff from the Bureau of Special Investigations (BSI).

The Grove Hall office is but one example of a number of offices where the Department's scope of programmatic responsibilities is such that the space is functionally inadequate. Moreover, such offices would not accommodate the introduction of MPACS, with its associated computer equipment, cabling and electrical requirements.

D. Increased Employee Morale

As a part of the Department's major effort to improve productivity in the field, several initiatives have been implemented since FY84. These include:

- o Error Rate Incentive - Upgrading for Direct Service Staff

Employee morale and motivation are critical to the task of reorienting the energies of the Department's local office staff towards lowering the error rate. With support from the legislature, effective January 1, 1985, the Department upgraded direct service field staff positions, as a reward for the successful efforts of field staff in lowering the error rates and as a strong motivator for continued performance.

- o Employee Awards and Incentives

As one means of rewarding exemplary performance by Department employees, the Department has established and participates in a variety of recognition awards and activities. The intent of these initiatives is to formally recognize individuals and groups of employees who have shown outstanding work performance. Examples of these awards include the certificate of recognition, the Commonwealth citation for Outstanding Performance, the Manuel Carballo Award, and the Commissioners Compassion Award. These awards for outstanding service are a recognition of the critical importance of the individual worker to the organization.

- o Training and Employee Services

- Professional Development. The Department has a strong commitment to the professional growth and development of its staff at all levels. Attendance at relevant workshops, conferences, seminars, and courses of study is an important method of improving worker skills. The following services and training are made available to Department staff:
 - retraining of clerical staff in an effort to keep pace with rapid advances in office technology;
 - retraining of local office direct service staff to enhance interviewing skills and improve worker/client relationships; and retraining of local office management, supervisory, and direct service staff to increase their knowledge of changing departmental, state, and federal policies and procedures.
- Employee Assistance Program (EAP). The Employee Assistance Program (EAP), implemented in FY85, is a voluntary, confidential, and professional counseling and evaluation service for employees and their family members who may be experiencing personal problems including family conflicts,

emotional difficulties, stress, and alcohol or drug-related concerns.

- Pre-Retirement Planning. The Department has established a voluntary Pre-Retirement Planning Program for all employees 55 years of age or above. This program, for which approximately 25% of the work force presently qualifies, is designed to provide employees nearing retirement age with information on both the practical and psychological dimensions of retirement.

THE FY87 AGENDA: IMPROVED SERVICE DELIVERY

The previously discussed error rate reduction initiatives, designed specifically to improve agency performance in the field have achieved considerable success. Worker productivity in the field has improved dramatically due to lower caseloads, increased training, and efforts designed to improve worker morale and motivation. In addition, local office physical work environments are now more conducive to quality performance.

In FY87, building on the base of the dramatic improvements in performance during the FY83 to FY86 period, the Department is proposing a second agenda of improvements in the delivery of services to clients across the Commonwealth. The changes that will be introduced in the Department's local offices in FY87 will result from the implementation of the Massachusetts Public Assistance Control System (MPACS) and other automated systems, and the re-structuring of the way in which work is performed in the local office. As a result of these changes, the FY87 agenda in the Local Office Operations account includes the following important initiatives:

- o Maintain low error rates;
- o MPACS implementation;
- o Improved service and benefit delivery to clients;
- o Assist clients in moving out of poverty;
- o Increased training; and
- o Local office improvements

A. Maintain Low Error Rates

The reduction of the error rates to their current levels was a major accomplishment which required the concerted effort of most of the agency's staff, most notably, workers in the local offices. To a significant degree, lower caseload-to-worker ratios were a major contributing factor in lowering the error rates. The need for lower caseload-to-worker ratios was due partly to the fact that the Department's eligibility computer

system is old and antiquated and the present eligibility determination and redetermination processes are paper-intensive. These obstacles were essentially overcome through more staff, and better management of paper by local office direct service workers, supervisors, clerks, and managers.

Though this approach to error reduction was successful, continuing and complex changes in federal policy and the inadequacies of the existing computer system mean that the Department would continue to be at risk of increased error rates. In order to maintain these low rates in the future, the Department needs MPACS.

In FY86 and FY87, the Department will seek to maintain error rates at their current low levels, and to reduce them further. Until the implementation of MPACS, this will require that local office workers continue to manage the paper intensive process, which by its nature is error-prone. Under the current paper-driven system there will always be:

- o errors in determining eligibility and benefits calculation;
- o too many forms, too much paperwork and too many cumbersome manual functions;
- o little flexibility to incorporate new requirements resulting from new federal and state legislation or court mandates;
- o inadequate computer-generated reports, necessitating supplementary manual reports;
- o delayed information retrieval, resulting in untimely issuance of benefits to clients and unnecessary manual duplication of work by field staff.

The full introduction of the Department's new eligibility determination system, MPACS, will eliminate most of these problems. The combination of highly motivated local office staff well trained on the new system and the system's own capabilities will make it substantially more likely that the Department can maintain low error rates in upcoming years.

B. MPACS

MPACS, which will be implemented statewide in the Department's local offices in FY87, is the Department's new, state-of-the-art automated eligibility determination and benefits issuance system. One of the basic concepts behind MPACS is that workers should substitute technology in place of time-consuming manual tasks whenever possible. With MPACS, workers in the Department's local offices will interview applicants "on line" and the system will automatically determine the applicant's eligibility and benefit

levels. Twice monthly the system will automatically issue cash assistance payments and monthly, it will issue Food Stamp Authorization to Participate (ATP) vouchers in the correct amounts to eligible Food Stamp program recipients. Making MPACS successful will involve a large systems development effort. Even more importantly, however, successful implementation will involve thorough training for workers in how to do their jobs using individual computer terminals instead of manually completing forms which are required for the agency's various programs. This is a substantial change and one which involves several thousand workers in 69 locations. The Department will therefore focus considerable attention in FY87 on the specifics of MPACS implementation. The system should enable the agency to maintain low error rates with less manual effort, meaning that workers will be able to focus more energy on assisting clients to move off welfare. The Department will delay making full use of this potential, explained below, until the agency is certain that the workers have successfully made the transition to handling their current responsibilities using completely new tools.

The successful introduction of this technology will provide the Department with the opportunity to restructure work both in the central office and in all 69 local offices in coming years. For example, when the local office direct service worker tracks client cases or recalculates eligibility based on changing client circumstance, that worker will input the changed data into the MPACS system. The computer will then automatically perform in a matter of minutes tasks which take the local office worker considerably longer to perform under the paper intensive system. Thus MPACS represents not just an improvement in systems automation, but a basically new approach to service delivery.

Full implementation of MPACS in FY87 will enable the Department to overcome the inherent limits and constraints associated with the current error-prone, paper-intensive processes. With MPACS, the Department will be able to:

- o maintain low error rates;
- o reduce the paper-intensity of the eligibility determination process; and
- o reduce the time required by workers to determine or redetermine eligibility and to conduct case maintenance activities.

C. Training

In FY87, the Department proposes to retrain or upgrade the skills of the entire field staff. MPACS success depends ultimately on its use by workers in the local offices. In fact, a survey of all local office workers indicates that training is considered by

all staff to be, by far, the most important factor in preparing for MPACS implementation. During FY86, a small staff of professional trainers will develop the training curriculum. They will then fully train the staff from the Department's Training Unit, who will, in turn conduct the training of all Department staff in FY87. The training curriculum will be modular, meaning that each worker will receive training specific to his or her job responsibilities. Supervisors will be responsible for learning the modules that apply to their unit and local office directors will be responsible for learning all of the training modules. This training agenda is the most ambitious in the history of the Department. Although the MPACS account (4400-1016) will fund the training, it is the local office direct service worker who will be most affected.

D. MPACS as a Tool for Improving Service Delivery

The quality and quantity of services that the Department can provide to clients at present is limited by the paper-intensity of the process and the lack of adequate computer capability. At present, local office direct service workers are providing clients with the basic benefits and services to which they are entitled, with a relatively high degree of accuracy, as demonstrated by the current error rates. However, the time constraints imposed by a paper process and computer system that is more than 15 years old prevents workers from managing effectively the services and benefits delivered to clients. More important, the constraints imposed by the current system, which can require the completion of more than 70 forms for the various programs, has resulted in the Department staffing local offices with workers who specialize in one program or another (AFDC workers, MA workers, ET workers). As a result, even under the caseload system, a local office worker does not serve the total needs of a client or family, thus reducing significantly any chance of a worker managing client outcomes. MPACS automation will enable the Department to move to a system where workers are responsible for managing services for clients instead of paper for an antiquated computer system.

This system will make it possible for workers to manage services on behalf of clients. This means that:

- o necessary services will be available more quickly;
- o social workers can begin to help manage the costs of the services they provide, especially Medicaid and EA; and
- o most important, social workers can become responsible for making sure that clients have maximum access to ET and other alternatives to welfare and are making progress toward moving out of poverty.

E. Local Office Improvements

In FY87, the Department proposes to renovate or relocate to better space eight of its local offices. These eight upgradings will bring the total number of local offices either relocated or renovated since FY83 to fifty.

These improvements in the working conditions of the Department's local offices have had a direct effect on worker performance and morale. Both performance, as measured by error rates and redetermination rates, and morale, as measured by staff turnover rates have improved significantly.

Additionally, in FY87, or the latter part of FY86, eight local offices -- Fall River, Framingham, Greenfield, Lowell, Marlboro, Plymouth, South Boston, and Westfield -- have leases which will expire. To continue in those buildings or relocate the Department will need to begin paying higher monthly rents.

THE FY87 REQUEST

The FY87 request for this account totals \$74,213,433. This FY87 request reflects the costs of 2,820 FTE positions, unemployment insurance, and the costs of rents for the Department's 69 local offices.

<u>Subsidiary</u>	<u>Component</u>	<u>FY87 Request</u>
(01)	<u>Personnel</u>	\$50,794,960
Funds requested in this subsidiary are for 2232 FTE positions, and does not include any additional staff.		
(02)	<u>Personnel</u>	\$13,826,254
Funds requested in this subisidary are for 588 FTE positions, and does not include any additional staff.		
(13)	<u>Special Supplies and Expenses</u>	\$ 110,000
The FY87 request of \$110,000 is the cost of unemployment insurance for all 01 and 02 positions shown as filled across all Department of Public Welfare accounts.		
(16)	<u>Rentals</u>	\$ 9,482,217
This subsidiary funds the rents for the Department's 69 local offices. The FY87 request includes the higher rents which will be incurred when the leases of eight local offices -- Fall River, Framingham, Greenfield, Lowell, Marlboro,		

Plymouth, South Boston, and Westfield -- currently under rental agreements, expire either during the latter part of FY86 or in FY87. The South Boston office is under a tenancy-at-will agreement; the other seven are under lease agreements.

TOTAL REQUEST

\$74,213,433

DEPARTMENT OF PUBLIC WELFARE LOCAL OFFICES



MPACS ACCOUNT (4400-1016)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 Request</u>
Expenditures*	--	--	\$14,962,157	\$18,600,000

WHAT IS MPACS?

The Massachusetts Public Assistance Control System (MPACS) is the Department's new, state-of-the-art eligibility determination and benefits issuance computer system. It represents a significant step forward in the use of information technology to support the operations of the Department. The basic concept behind MPACS is that workers should substitute technology in place of time-consuming manual tasks whenever possible. This allows for more efficient and accurate determination of whether a new applicant meets or a recipient continues to meet the eligibility criteria for the different assistance programs the Department administers in its 69 local offices. ..

At present, the Financial Assistance Social Worker (FASW) in the local office takes down the information from clients by hand, using the more than 70 forms required for the various assistance programs: AFDC, Food Stamps, General Relief, Medicaid, and Refugee Assistance. This handwritten process is so slow that the average time required for an initial AFDC eligibility interview is 2.6 hours and for an AFDC redetermination interview 1.8 hours. The client information from these forms is later entered into the Department's current eligibility computer system, the Financial Management and Control System (FMCS), by data entry clerks in the local offices, thus creating the Department's basic eligibility database. The database is updated through this cumbersome process each time new or revised client information is received, with the central eligibility file updated nightly.

With MPACS, this process will be replaced by a fully automated system based on an integrated intake interview. The key features of MPACS include:

- o an integrated telecommunications network

All local office workers will have computer terminals and printers, which will be linked to a centralized eligibility

* Prior to FY86, MPACS expenditures of \$2,770,000 in FY84 and \$4,633,292 in FY85 were funded in the Systems account (4400-1010) and the Contract Operations account (4400-0900). The legislature established the MPACS account as an FY85 supplemental appropriation, although the expenditures of \$14,962,157 will be incurred during FY86.

database through a statewide communications network. Thus, client files in any one local office can automatically be matched against files in another office. At present, if an AFDC client moves, for example, it takes 15 different actions with 5 different forms, involving 30 hours of processing time to complete the case transfer from one local office to another.

o on-line entry and update of information

Information about clients and services will be entered into the system by social workers, supervisors, or other local office personnel using these terminals.

When a client applies for assistance, the intake interview will be interactive: a series of screens displayed on the terminal will guide the worker and client through the application, progressively selecting the appropriate questions to ask, depending on the information that the client has just provided. At present, workers must spend time going through sections of forms even when they are not relevant for a particular client.

The intake interview will also be integrated: eligibility for all assistance programs administrated by the Department will be determined from this one application. This will eliminate the necessity of clients having to repeat the same information on different forms for different programs.

o timely processing of information

In most instances, client information will be processed as it is received, updating the MPACS eligibility database immediately. For example, at the end of the intake interview, the system will automatically determine the applicant's eligibility and benefit levels. When the worker enters information about changes in client circumstances into the system, eligibility and benefit levels will automatically be recalculated. Current delays in recording updated information increase the probability of client error.

Twice monthly the system will automatically issue cash assistance payments and once a month it will issue Food Stamp Authorization to Participate (ATP) vouchers in the correct amounts to eligible program recipients. This will both improve service to clients and tighten management control within the Department. Current systems are so slow that, for example, clients may have to wait a full month to receive improved benefits for which they become eligible. Furthermore, workers in local offices frequently have to issue supplemental, adjustment or emergency checks by hand, since current systems have only limited capability to reconcile benefit levels with changes in client circumstances. Full accountability is lacking for such manual financial transactions.

The Department's strategy in MPACS has been to design a computer system that facilitates the entry and retrieval of client information in a

flexible and useful manner. By freeing up worker time through the automation of manual tasks, MPACS also provides the opportunity to fundamentally restructure the work flow in local offices and in the central office. Thus, MPACS represents not just an improved computer system, but the opportunity to implement a basically new approach to service delivery.

MPACS is structured into four subsystems:

- o The Client Certification Subsystem, which will provide the on-line processing for eligibility determination, establishment of benefit levels, and verification. This subsystem is organized into four major functions:
 - Intake and Initial Eligibility
 - Ongoing Eligibility
 - Employment and Training
 - Interfaces
- o The Financial Information and Control Subsystem, which will issue benefits, reconcile the Department's financial records with those of the Comptroller, and provide financial reports.
- o The Management Information and Control Subsystem, which will provide Department managers with detailed information on clients and on agency operations. This subsystem will assist in monitoring worker performance and in promoting accountability.
- o The MPACS Support Subsystem, which will provide the support necessary for the maintenance, security and enhancement of the fully operating system.

MPACS is the most sophisticated and comprehensive automated eligibility system to be installed in any state. It is also the largest single systems project ever undertaken by the Department of Public Welfare, involving a four year development effort. The statewide implementation of MPACS in all local offices during FY87 is a complex management task requiring a substantial commitment of resources.

WHY WE NEED MPACS

The Financial Management and Control System, or FMCS, the Department's current eligibility system, was developed in 1970 as a simple record-keeping and check-writing computer system for the Boston region of the Department of Public Welfare. Since that time, an early period in computer development, the Department has expanded and modified the system on a fragmented basis, frequently under crisis conditions, to incorporate the many changes in state and federal welfare programs over the past 15 years. Consequently, this system has evolved from a simple check-writing system into an overly complicated patchwork system that performs

a variety of eligibility determination and benefit issuance operations with only mixed success. FMCS reached its original modification limit eight years ago, resulting in the need for manual procedures to ensure management accountability and control. Specific FMCS problems include:

- o errors and delays for clients in determining eligibility and calculating benefit levels.
- o too many forms, too much paperwork and too many cumbersome manual functions. Workers currently must fill out by hand over 70 forms associated with the Department's major assistance programs.
- o limited flexibility in incorporating new requirements resulting from new federal and state legislation or court mandates. Workers often are forced to incorporate new requirements by hand during eligibility determination or redetermination interviews.
- o questionable data integrity due to the lack of valid controls and edits. Inaccurate or outdated client information is inadvertently left in eligibility files.
- o inadequate computer-generated management reports necessitating supplementary manual reports.
- o delayed information processing and retrieval, resulting in untimely issuance of benefits and unnecessary manual duplication of work by local office staff.

In sum, the current data processing system is inefficient to operate and to maintain. Since the Department depends on computer systems to store and update eligibility data for over 500,000 recipients, issue cash assistance benefits of approximately \$600 million to recipients, and process over 19 million claims resulting in payments of over \$1.2 billion to vendors, this inefficiency adds unnecessary extra costs to administering the Department's programs.

Determining client eligibility for AFDC, Food Stamps, Medicaid, General Relief and Refugee Assistance programs is the central task in the administration of service delivery in the Department's 69 local offices. During FY87, social workers in local offices will, each month:

- o determine initial eligibility of 7,000 AFDC, GR, and Refugee Assistance applicants.
- o redetermine the eligibility of 19,000 AFDC, GR, and Refugee Assistance recipients.
- o determine the initial eligibility of 4,800 Medicaid applicants.
- o redetermine the eligibility of 7,500 Medicaid recipients.
- o perform case maintenance activities on 12,000 cases.

- o determine the initial eligibility of 7,100 non-publicly assisted Food Stamp applicants.
- o provide emergency assistance to more than 1,200 clients.

In addition, the Department will issue 225,000 assistance checks, 139,000 Food Stamp Authorization-to-Participate (ATP) vouchers, and 260,000 Medicaid identification cards to eligible households each month.

This ongoing volume of client transactions is larger than that of any other state agency. With the inadequacies of current systems, this high volume cannot be processed efficiently, which prevents needy individuals and families from receiving the services and benefits to which they are entitled and contributes to error rates. The Department simply has outpaced the system's ability to support its ambitious agenda of agency goals.

A comprehensive, integrated system, such as MPACS, is essential to overcoming the inadequacies of current systems and improving further the Department's performance. Responding, in an ad-hoc fashion, to specific problems as they arise needs to be replaced by coordinated responses that are focused on the Department's basic mission of delivering services and issuing benefits to the state's eligible individuals and families in an accurate, timely and efficient manner. The implementation of MPACS will result not only in correcting specific computer deficiencies that currently exist, but in allowing workers to substantially improve service delivery in the local offices.

MPACS BENEFITS

MPACS is essential for maintaining the Department's low error rates at or below federal fiscal sanction levels (3% for most programs), and for realizing the Department's ambitious service delivery, management and savings and revenue goals. The Department anticipates that MPACS' key benefits will include:

- o maintaining lower rates;
- o improving services to clients;
- o eliminating time-consuming paper work;
- o increasing savings and revenue performance; and
- o improving the completeness of the Department's database.

A. Maintaining Low Error Rates

On-line determination of eligibility and benefit levels, automated tracking and verification of client circumstances, and timely automatic eligibility redetermination will allow the Department to maintain or reduce its already low error rates in order to avoid costly federal sanctions.

Since FY84, the Department, with the support of the administration and the legislature, has introduced a number of initiatives to improve agency performance in local offices. To date, these initiatives have achieved considerable success, especially in reducing the error rate to the lowest level in the agency's history: 3.0% for AFDC and 1.2% for Medicaid. However, current ways of delivering services contain an unacceptable residual level of error. Maintaining these low error rates over time requires more extensive automation. Error is comprised of both agency error and client error. MPACS will reduce agency-caused error in the following ways:

- o Automated policy and policy changes will ensure correct and consistent application in the Department's 69 local offices. All workers will receive policy changes on-line. Changes will be automatically incorporated into the eligibility determination functions of MPACS and applied uniformly for all applicants statewide.
- o Required verification of all information prior to benefit issuance. No benefits will be issued until the worker has recorded in the system that all required verifications of client information has been completed.
- o Automated follow-up to alert workers of impending changes that affect eligibility. This function will alert workers to events that will require a redetermination, such as a child about to reach his 18th birthday.
- o Automated benefit calculation will eliminate computational errors.

MPACS will also have an effect on client-caused error. MPACS will relieve workers of the burdens imposed by a manual system that ties up worker time with paperwork and clerical functions. In turn, this will allow for more frequent and more extensive interaction between workers and clients, resulting in the more timely discovery of changes in client circumstances.

B. Improving Services to Clients.

MPACS will reduce the likelihood of under-issuance of benefits and identify additional programs for which recipients are eligible. MPACS will also automate the process of notifying clients about the availability of programs, such as ET, that provide clients with alternatives to poverty.

In sum, MPACS will benefit the Department's clients by increasing the productive capacity of the local office worker. The quality and quantity of services that the Department can provide to clients at present is limited by the paper intensity of the eligibility determination process. Workers must spend much of their time managing paper, rather than managing effectively the services and benefits delivered to clients. Relieved of the burdens and

constraints of the current system, the Department's social workers will be capable with MPACS of assuming new responsibility for client welfare. The Department proposes to use this increase in the productive capacity of its workers to accomplish two major goals in FY87:

- o Service delivery which responds adequately to client circumstances and makes ET and other alternatives to poverty more available to clients.
- o Service delivery that uses social workers to better manage the delivery and costs of benefits.

C. Eliminate or Automate Paperwork

Workers are currently burdened with completing over 70 forms associated with eligibility for the Department's major assistance programs. Automation will free up time for promoting anti-poverty initiatives to provide clients with alternatives to welfare, as well as for error reduction activities.

D. Increase Savings and Revenue Performance by Automating Recovery and Recoupment

MPACS will automatically recoup the monthly portion of overpayments which active cases owe and will automatically generate notices to closed cases. Improved tracking and matching capabilities will allow for increased cost savings due to improved third party liability identification of Medicaid recipients, for example.

E. Improve Completeness and Flexibility of Department's Eligibility Database

These improvements will enable the Department to perform more frequent and accurate computer matches to verify client income and asset information.

PERFORMANCE 1983 - 1986

A. Design -- Part I

Managing a project of this complexity is a major task, requiring a substantial investment of resources. Work on MPACS dates from FY84, when the Department began the development and planning process. An outside contractor was competitively selected to provide the programming services required to design the system. By the end of FY86, the first part of MPACS, the design of the basic eligibility determination and benefits issuance system, will be complete.

B. Review and Testing

The four basic MPACS subsystems described earlier will be fully tested and will begin pilot operation in the Roslindale local office

before the end of FY86. Roslindale, a large Boston office, delivers a complex mix of services to a broad spectrum of clients, providing a rich setting for testing the full range of MPACS' capabilities and for observing the improvements in service delivery that MPACS makes possible. Any necessary adjustments in the design of the system will be identified and completed well before statewide implementation.

An outside contractor will be competitively selected to conduct a Systems Acceptance Test (SAT) of MPACS. This test provides the Department with independent assurance that MPACS' design and performance adheres to contract specifications. An outside contractor will also be competitively selected to provide, through a service bureau, the data processing services necessary to support the management of the MPACS system on an ongoing basis. These services include computer equipment, operating software, and personnel. The contractor will be required to meet established performance standards and cost specifications.

C. Preparation for Implementation

Alterations in the Department's 69 local offices will be required in order to accommodate the necessary computer equipment, principally terminals, printers and controllers. Over 3,000 terminals will be installed. Coaxial cabling, enhanced electrical service, non-glare lighting, air conditioning for the controller room, and some incidental carpentry for security and other renovations are required. Providing a secure system of electrical power distribution through the installation of transformers, panels, outlets and wiring is especially important. The lack of adequate, secure electrical power would jeopardize the operation of a complex computer system such as MPACS. Independent contractors to do this retrofitting will be selected and work will commence in FY86. The necessary operations of the local offices will continue uninterrupted during retrofitting. Purchase and installation of the computer equipment in the offices will follow the completion of retrofitting.

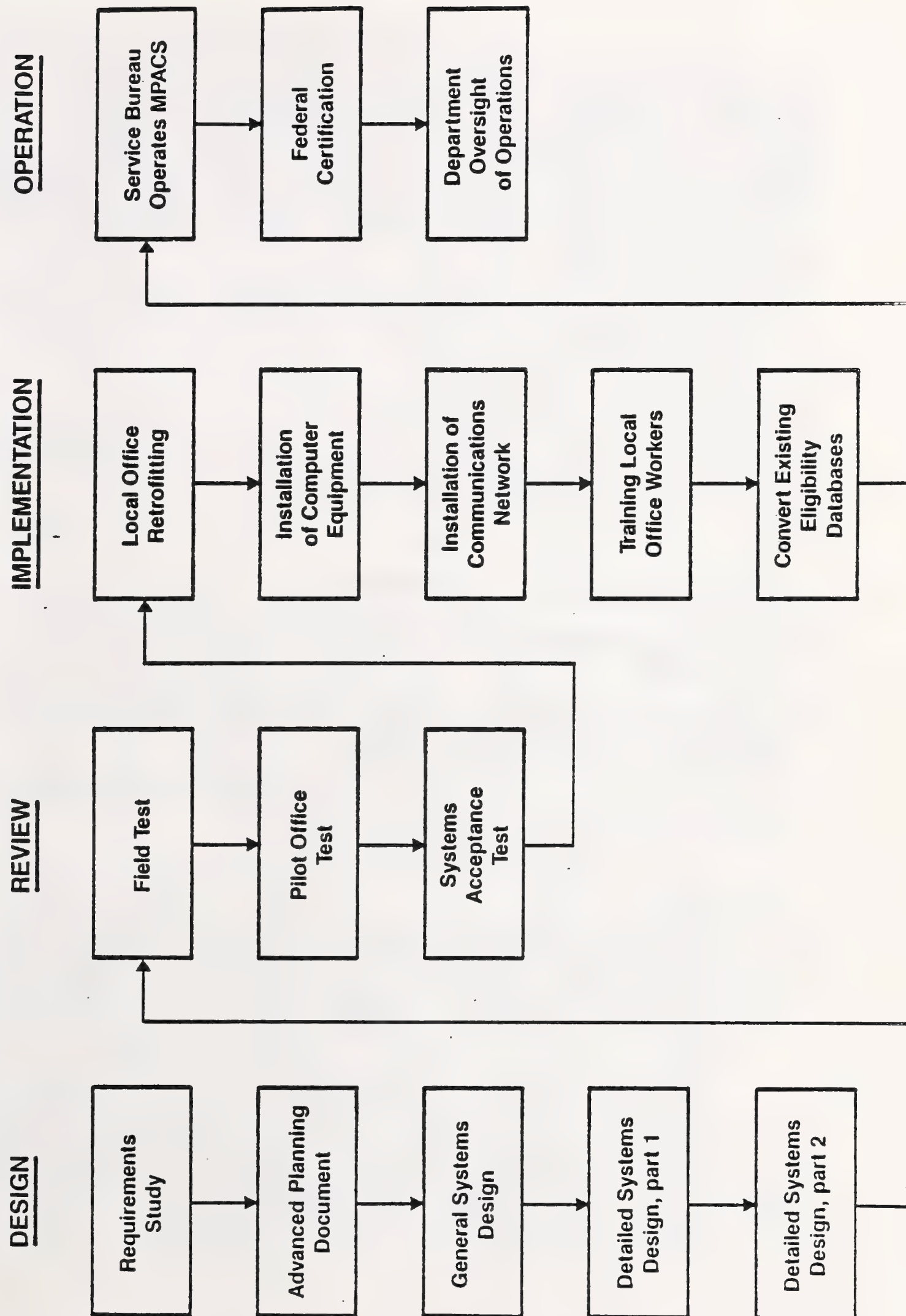
MPACS' success in improving service delivery depends ultimately on its use by workers in the field. A survey of local office workers indicates that computer training is considered by all staff to be, by far, the most important factor in preparing for MPACS implementation. During FY86, a curriculum for training workers to use MPACS will be developed. Staff from the Department's training unit will also be fully trained in the technical and management aspects of MPACS, so that they may then conduct the training of all Department staff during FY87.

These extensive efforts from FY84 through FY86 have provided a solid foundation for MPACS statewide implementation during FY87.

FY87 INITIATIVES: STATEWIDE IMPLEMENTATION

The major MPACS initiative for FY87 is statewide implementation in all 69 of the Department's local offices. Since MPACS makes possible a new

MPACS DEVELOPMENT PLAN



approach to service delivery based on the integrated intake interview, implementation means a restructuring of local office operations. Thus, the entire Department of Public Welfare will be part of MPACS implementation, whereas the design of MPACS was accomplished by a smaller number of programming staff from an outside contractor and the Department's Systems Division. Successful completion of a Department-wide project of this complexity requires careful project management to coordinate the diverse tasks involved in preparing for MPACS operations. These tasks include:

- o the design of the second phase of MPACS -- tracking, forecasting and reporting
- o the pilot office test
- o the Systems Acceptance Test
- o the retrofitting of all local offices and the installation of computer equipment, including over 3,000 terminals
- o the installation of the statewide communications network
- o the training of 4,000 local office workers
- o the conversion of the Department's existing eligibility files to MPACS

Furthermore, the Department is committed to maintaining the uninterrupted provision of services and benefits to clients during the transition period from current systems to MPACS.

Each of these tasks is described briefly below and is depicted as part of the overall MPACS Development Plan in the chart on the following page.

A. Design -- Part II

The second phase of MPACS design will be completed during the first half of FY87 and will supplement the basic system designed in FY86. Part II design will expand the system's capabilities for tracking, forecasting and reporting, greatly improving the system's versatility in promoting management control and accountability. This design phase will also incorporate the expanded computer matching capability being developed in the State Income and Eligibility Verification System. Prompt and accurate matching of the MPACS eligibility database with insurers and financial institutions, the Internal Revenue Service, the Social Security Administration, and other state agencies, such as the Department of Revenue, the Division of Employment Security and the Registry of Motor Vehicles, will increase the Department's ability to verify recipient income and asset information and to recoup overpayments.

B. Pilot Office Test and Systems Acceptance Test

All of the MPACS design will be fully tested in the Roslindale pilot office prior to statewide implementation. An independent contractor will complete the Systems Acceptance Test and certify to the Department that MPACS, as designed and implemented, meets expected performance standards. This is a critical step in securing continued federal financial participation. Not only will the pilot office test assess the performance of the MPACS software and hardware, but it will assess the improvements in local office operations and service delivery made possible by MPACS. MPACS will allow social workers to assume new integrated programmatic responsibilities. As integrated eligibility workers, they will assist clients in applying for any of the assistance programs that the Department administers. They will also more intensively market the services and benefits offered by more specialized workers in the local offices: Employment and Training, Project Good Health and other related health choices, and child support. Evaluation of client and worker responses to this new service delivery system will assist the Department in refining the system before implementing it in all local offices.

C. Training

Training 4,000 local office workers -- including social workers, supervisors, managers and clerical workers -- to use MPACS is itself a complex undertaking. All workers will receive an intensive three day introduction to MPACS operations at a centrally located training center. Additional training will take place in the local offices. The training will be computer-based, so that workers will learn the new system at their own terminals. Training staff will be available in each local office to provide ongoing assistance as needed. Computer-based training provides the "hands-on" experience required to master the new system and to prepare for a smooth transition to MPACS.

D. Retrofitting and New Statewide Communications Network

Before this computer-based training can take place, the local offices must be retrofitted and the computer equipment installed. The communications network linking together MPACS terminals and printers must also be designed and installed. Phone lines will run from the local offices to the state's Bureau of Computer Services in Boston, then to the service bureau.

E. Conversion of Current Files to MPACS

The MPACS management team will provide technical support for Department staff in the central office and the local offices. One major task will involve converting the existing eligibility files on FMCS to MPACS specifications so that the Department retains, on one integrated database, relevant information on all current recipients plus all former recipients for the last three years.

The management team will also be responsible for monitoring the performance of all outside contractors, checking for adherence to contract specifications, and assuring the compatibility of the system's technical design with Department needs. Once MPACS becomes fully operational later in FY87, the day-to-day management of the system will be turned over to the service bureau. However, the Department's MPACS management team will oversee and evaluate the service bureau to make certain that established performance standards and cost specifications are met.

With statewide implementation of MPACS, the state will begin to realize the substantial benefits of MPACS discussed earlier. FY87 represents the final and the most critical installment on a multi-year development and implementation effort. With federal financial participation, however, the state receives substantial federal reimbursement for the costs of developing and operating MPACS. Thus the state's share of development costs is, on average, only 15%, while the state's share of operational costs is, on average, only 50%. For FY87, therefore, the state's share of MPACS costs is projected to be only 25% to 50% of the total. Thus, expenditures on MPACS are an investment in modernizing the Department's operations at moderate cost to the state.

FY87 REQUEST

The Department's FY87 MPACS request totals \$18,600,000. This amount represents the continuation of FY86 activities.

<u>Subsidiary</u>	<u>Component</u>	<u>FY87 Request</u>
(03)	<u>Technical/Professional Services</u>	\$12,828,249

In FY87, the Department is requesting \$12,828,249 in (03) subsidiary contract funds for technical/professional data processing services. This total represents a continuation and annualization of FY86 activities. No expansion is requested. The 03 subsidiary contains funding for the following initiatives:

1. Consultec, Inc.	\$2,550,275
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\$1,200,275 in (03) contract funds are requested for completing the development and testing of MPACS during the first half of FY87. The state's share of this expenditure will be only 15%, or approximately \$180,000

With the completion of MPACS, the Department's contractor will still be responsible for providing ongoing technical support during the statewide implementation of the system. \$1,350,000 in (03) contract funds are requested to support these services. The state's share of this expenditure will total 15%, or approximately \$202,500.

2. Service Bureau	\$6,955,000
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The Department proposes to enter into a contract to procure the data processing services necessary to support the operation, maintenance and management of the MPACS system. The estimated cost for FY87 is based on 70% of a full year of operations, to reflect the phase-in of MPACS operations during this year. The state's share of this expenditure, in FY87 and in future years, will be 50%, or approximately \$3,477,500 in FY87.

3. MPACS Management Team \$2,049,647

The Department's MPACS management team has the critical task of managing the largest single systems project ever undertaken by the Department. They will be coordinating the statewide implementation of MPACS in all 69 local offices. \$2,049,647 in (03) contract funds are requested for this purpose in FY87. The state's share of this expenditure will total 15%, or approximately \$307,000.

4. MPACS Training \$604,578

The success of MPACS depends ultimately on its use by workers in the field. To train Department staff for MPACS, \$604,578 in (03) contract funds are requested for FY87. The state's share of this expenditure will total 15%, or approximately \$91,000.

5. Systems Acceptance Test \$668,749

The Department proposes to competitively procure the services of an outside contractor in order to test MPACS' performance for its adherence to contract specifications. The state's share of this expenditure will total 15%, or approximately \$103,000.

(12) Maintenance and Repairs \$1,572,760

The Department is requesting \$1,431,250 in FY87 to fund local office retrofitting. Most of the Department's 69 local offices will be fully retrofitted for MPACS in FY86. However, some offices will be relocating at the end of FY86 with the expiration of their leases. Thus, the cost of coaxial cabling, electrical wiring, parabolic lighting, security and other renovations will extend into FY87. The state's share of this expenditure will total 50%, or approximately \$716,000.

The Department is also requesting \$141,510 in data processing maintenance services, of which \$130,870 represents an adjustment for the Department's mainframe computer, based on a full-year's charge, less 25% to reflect the phase-in of MPACS operations. The state's share of this expenditure will total 15%, or approximately \$21,000.

(13) BSO User Charges \$401,625

Data processing support services for MPACS will be required from the Bureau of Systems Operations until the system becomes fully operational during the latter half of FY87, and these services are provided entirely by the service bureau. The Department's estimate of user charges to the

Department is derived from Office of Management Information Services (OMIS) estimates for a full year of operations, reduced by 25% to reflect the phase-in of MPACS operations. The state's share of this expenditure will total 15%, or approximately \$60,000.

(14) Office Operations \$1,026,250

This subsidiary request supports two separate activities. Estimated telephone operating costs of \$595,000 reflect charges for telephone linkage from the local offices to the central computer system. These dedicated lines are required to assure the integrity of data transmission. The installation of new lines and upgrading of old lines commenced in FY86 and will be completed in FY87. The amount requested is based on 70% of the estimate for a full year's operation, to reflect the phase-in of MPACS operations. The state's share of this expenditure will total 50%, or approximately \$297,500.

\$431,250 is also requested for data processing supplies in the local offices which will be required by MPACS. These include all implementation-related supplies, such as computer printer paper, tapes, discs, printing of manuals, and overhead materials for MPACS. The state's share of this expenditure will total 50%, or approximately \$215,600.

(16) Equipment Rental \$2,771,116

This subsidiary request reflects the estimated FY87 installment purchase cost of the five year municipal lease purchase of terminals and related data processing equipment for the local offices. Cost estimates are based on the most recent offer to the Department. The offer encompasses 3,100 video display terminals, 69 eight port controllers, 112 thirty-two port controllers, 376 dot matrix printers, 169 laser printers, and 122 character printers. This cost also includes maintenance charges. The state's share of this expenditure will total 15%, or approximately \$415,700.

Total FY87 Request \$18,600,000

SYSTEMS ACCOUNT (4400-1010)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures	\$1,711,177	\$5,028,259	\$1,103,803	\$4,361,999

The basic mission of the Department of Public Welfare is to deliver services and issue benefits to the state's eligible low-income individuals and families in an accurate, timely and efficient manner. To accomplish this mission, the Department must store and update eligibility data for over 500,000 recipients, issue cash assistance benefits of approximately \$600 million to recipients, and process over 19 million claims resulting in payments of over \$1.2 billion to vendors. Processing this amount of data would be impossible without sophisticated computer systems.

Determining client eligibility for AFDC, Food Stamps, Medicaid, General Relief and Refugee Assistance programs is the central task in the administration of service delivery in the Department's 69 local offices. During FY87, social workers in local offices will, each month:

- o determine initial eligibility of 7,000 AFDC, GR, and Refugee Assistance applicants.
- o redetermine the eligibility of 19,000 AFDC, GR, and Refugee Assistance recipients.
- o determine the initial eligibility of 4,800 Medicaid applicants.
- o redetermine the eligibility of 7,500 Medicaid recipients.
- o perform case maintenance activities on 12,000 cases.
- o determine the initial eligibility of 7,100 non-publicly assisted Food Stamp applicants.
- o provide emergency assistance to more than 1,200 clients.

In addition, the Department will issue 225,000 assistance checks, 139,000 Food Stamp Authorization-to-Participate (ATP) vouchers, and 260,000 Medicaid identification cards to eligible households each month.

This ongoing volume of client transactions is larger than that of any other state agency and could not be managed effectively without computer support. Failure to manage this high volume would prevent needy individuals and families from receiving the services and benefits to which they are entitled and also would result in high error rates.

The Systems account (4400-1010) supports the core day-to-day service activities of the Department's Systems Division. It funds the salaries of the data processing professionals who manage the Department's computer systems. In order to further enhance systems support, the Department requests that in FY87 data processing expenditures previously recorded in different accounts be centralized in the Systems account.

The Department's two major free-standing computer systems would remain funded in separate accounts: the Medicaid Management Information System (MMIS) in (4400-1012) and the Massachusetts Public Assistance Control System (MPACS) in (4400-1016). Child Support Enforcement Systems are funded in (4400-1014).

PERFORMANCE 1983-1986

The legislature established the Systems account in FY84 to assist the Department in managing its own computer systems. Since then, the Department, with continued support from the administration and the legislature, has made a substantial commitment of resources to modernizing its systems and to upgrading its systems staff. Data processing professionals with experience designing, implementing, and managing large, complex, state-of-the-art systems have been recruited from the private and public sectors. The use of a more technically sophisticated manner of storing data -- data base management -- has resulted in systems with increased flexibility and speed in retrieving data. These factors are critical for the kind of data processing that the Department depends on, including:

- o incorporating new policies and procedures;
- o updating recipient eligibility data;
- o obtaining new information during worker-client interviews; and
- o retrieving data to support management decision making.

Many of the Department's successes in attaining critical client service and management goals between FY84 and FY86 could not have been achieved without enhanced computer systems:

- o reducing AFDC and Medicaid error rates to the lowest levels in the agency's history. The current AFDC error rate is 3.0% and the current Medicaid error rate is 1.2%. These error rates are a fraction of what they were 2 1/2 years ago, when the AFDC error rate was 11.6% and the Medicaid error rate 3.1%. Improving the Department's computerized eligibility files has contributed significantly to this error rate reduction. For example, the types of cases most likely to contain errors are now automatically identified and summarized for local office workers in a Prioritized Activities Listing.
- o avoiding AFDC and Medicaid error rate sanctions. This reduction in error rates has saved over \$40 million in potential error rate sanctions in the past 2 1/2 years.

- o avoiding Medicaid penalties under the 1981 Omnibus Budget Reconciliation Act (OBRA). More efficient data processing contributed to keeping Medicaid costs below the federal target level set by OBRA, which has saved \$24 million in potential penalties.
- o achieving the largest growth in savings and revenue activities in the agency's history -- from an actual \$92.1 million in FY83 to \$303.4 million in FY85, to a projected \$358 million in FY86. Improved systems contributed to this growth through:
 - the successful implementation of MMIS, the sophisticated Medicaid claims review and payment system, which has saved the Commonwealth's taxpayers \$63.5 million since its inception.
 - dramatic management improvements in the Finance Division's ability to recoup overpayments to recipients and providers, in the Department's ability to collect a record \$45 million in child support last fiscal year despite a declining AFDC caseload, and in other agency activities.

Improving on these accomplishments in FY87 will depend on the continued upgrading of systems support, which can only be as good as the Department eligibility files on which it relies. The current files, produced by the Department's 15 year old Financial Management and Control System (FMCS), are inadequate and still error-prone. The Department has undertaken a major development effort, beginning in FY84, to replace FMCS with a state-of-the-art integrated eligibility determination and benefits issuance system, MPACS --- the Massachusetts Public Assistance Control System. The Department plans to implement MPACS statewide in all local offices during FY87.

CURRENT SYSTEMS

The Department's computer systems, except for MMIS, run on the mainframe computers located at the Boston headquarters of the state's Bureau of Computer Services. A communications network links terminals and printers in the Department's 69 local offices and in the central office with these mainframe computers. The Department's larger computer systems support the core local office operations of eligibility determination and re-determination, as well as benefits issuance and claims payment. The Department also utilizes several smaller independent computer systems to manage its own resources more efficiently.

A. Eligibility Operations

- o The Financial Management and Control System (FMCS), developed in 1970 as a simple record-keeping and check-writing system for the Boston region of the Department of Public Welfare, is the oldest and best-known Department computer system. It stores client eligibility data on two separate files, the recipient master file and the dependent master file, for every case in each of the major assistance programs that the Department administers, including AFDC, Food Stamps, General Relief, Medicaid and Refugee Assistance. The files are updated nightly to reflect all changes in the status of clients which are received from local offices. Twice a month, the system issues cash assistance payments. Once each month, it issues Food Stamp Authorization-to-Participate (ATP) vouchers to eligible program recipients.

Since 1970, an early period in computer development, the Department has expanded and modified FMCS on a fragmented basis, frequently under crisis conditions, to incorporate the many changes in state and federal welfare programs over the past 15 years. Consequently, FMCS has evolved from a simple check-writing system into an overly complex patchwork system that attempts with only mixed success to perform a variety of eligibility determination and benefit issuance operations. FMCS reached its original modification limit eight years ago. Moreover, because of this modification limit, manual procedures have become necessary to substitute for FMCS's inability to retrieve necessary information for management accountability and control purposes.

- o The Monthly Income Reporting System (MIRS). The Department needs up-to-date income information from clients in order to avoid overpayment of benefits. With MIRS, the approximately 7,000 AFDC and Refugee Assistance recipients earning any type of income, or with a history of earned income, are sent a monthly report, which they must complete with information on their earnings and return to a case worker who enters the information on the system. MIRS then automatically adjusts the grant level based on this new information. Both FMCS and MIRS have been enhanced to identify cases most likely to contain errors and to support other error reduction initiatives in the local offices.
- o The ADABAS Data Base Management System. The large amounts of data stored on the recipient master file, the dependent master file, and several of the Department's other data files are organized on the ADABAS Data Base Management System. The speed and flexibility in retrieving information on clients that this system provides are essential for the day-to-day case management activities in the local offices and in the central office.

Neither FMCS nor MIRS, both antiquated, meet the Department's eligibility determination needs in today's complex environment. The Department plans to replace them with the new integrated eligibility determination system, MPACS. However, throughout the

transition year of FY87, the Department will continue to depend on the current systems for eligibility determination, benefit issuance and claims payments. The maintenance and enhancement of these systems is required to assure continuity in the Department's day-to-day operations and to manage the high volume of client transactions in the local offices.

B. Management Support

- o The statewide Personnel Management Information System (PMIS) is an automated personnel and payroll system. Prior to its implementation in FY84, the Department had to manually process weekly payroll transactions for over 5,000 employees. The major benefit of this system is its ability to process more quickly changes in payroll and personnel information. In FY85, after more than six months under PMIS, the Department committed itself to reducing the staffing level in its personnel and payroll unit by more than 70%, from 75 FTEs to 20 FTEs. These reductions will be completed by the end of FY86. The information PMIS provides, moreover, has been a critical factor in the Department's ability to reduce its staff by 150 from 4,603 in FY84 to 4,453 by the end of FY86.
- ..
- o The Massachusetts Integrated Departmental Accounting System (MIDAS) is an automated appropriation accounting and accounts payable system. The MIDAS system supports the internal management of the agency's financial operations by automating labor-intensive tasks and by providing increased information for planning, budgeting and control. It also supports an efficient connection to the Comptroller's state appropriations accounting system. MIDAS automatically maintains two sets of accounting records. An internal set provides information on a cost center basis for Department management purposes, while a set congruent with the Comptroller's system allows for a daily automated exchange of all financial transactions, including payment vouchers, encumbrances, and journal entries. This system will be replaced during FY87 with the more comprehensive Massachusetts Management Accounting Reporting System (MMARS).
- o The new Special Services Payment System (SSPS) was designed and implemented in FY86 by Department staff. It is a good example of the sophisticated in-house capability developed in the Systems Division since FY84. This system replaces the antiquated Non-Medical Vendor Payment System. It processes vendor claims for non-medical services provided to AFDC and GR clients, primarily for Emergency Assistance (EA), including emergency shelter for homeless individuals and families. With the recent dramatic increase in homelessness, especially among families with young children, total EA expenditures rose substantially between FY83 to FY86, far outstripping the capabilities of the old system to manage the delivery of these services. The new system will give the Department greater control over authorizations for payments by checking for client eligibility through on-line edits at the

time vouchers are issued. It will also maintain historical eligibility and payment data which will allow the Department to ensure that vendors are not paid twice and that EA payments to clients do not exceed established limits. Finally, the system will ensure that payments are issued quickly, encouraging vendors to provide services to homeless clients. It is projected that with SSPS and other initiatives, EA expenditures for FY87 can be held to \$39.1 million. This is only a 15% increase over FY86, which reflects significantly less growth than has occurred in recent years.

- o Information Centers and the Help Desk provide on-going management support services to all Department staff. It is important for the success of any computer system that those using it have ready access to expert advice whenever they have questions. There are information centers in the two central office locations of 180 Tremont Street and 600 Washington Street. Assistance is provided to central office staff on a daily basis as they make use of the Department's computer systems. The Help Desk provides assistance on an "on-call" basis to local office staff. With the implementation of new systems, including MPACS, demand for this service is projected to increase in FY87.

FY87 INITIATIVES

In order to realize its ambitious direct service, management, and savings and revenue goals for FY87, the Department proposes to maintain its current computer systems and to enhance them through four major initiatives funded completely or partially from the Systems account: statewide implementation of MPACS, office automation, the State Income and Eligibility Verification System (SIEVS), and the Massachusetts Management Accounting Reporting System (MMARS). Other initiatives will be funded out of the Medicaid Management Information System (4400-1012), Child Support Enforcement Systems (4400-1014), and Massachusetts Public Assistance Control System (4400-1016) accounts.

A. Statewide Implementation of MPACS

The Department's major systems initiative for FY87 is to successfully implement MPACS statewide. While MPACS implementation itself is funded through the MPACS account (4400-1016), Systems Division staff, funded in this account, will continue to assume management responsibility for this project. This is the largest single systems project ever undertaken by the Department of Public Welfare, and its implementation will require a sustained and coordinated management effort. The Systems Division's MPACS management team will provide leadership for this effort by working with Department staff, and providing management and technical support as needed. Even though an independent contractor will be managing the day-to-day operation of MPACS once it is implemented, Systems Division staff will still be responsible for the oversight and evaluation of the contractor's performance to assure that MPACS' full benefits are realized. The Systems Division will also expand its ongoing efforts to manage the

Department's other computer systems in order to provide a smooth linkage between them and MPACS.

B. Office Automation

Office automation is the Department's second systems initiative for FY87. Office automation technology has only recently arrived at the Welfare Department. The first personal computers were not installed in the Department until 1983. Because of the benefits of office automation, the Systems Division established an Office Automation Unit and began a pilot office automation project within the Medical Division in FY86. In addition to funding the salaries of the data processing professionals required to develop and implement office automation systems, the Department proposes that the Systems account fund the purchase of data processing equipment in FY87. In FY86, office automation projects were funded in the Management and Support (4400-1000) and the Medicaid Management (4400-1003) accounts.

An office automation system consists of an integrated network of computer and communications equipment. Up to 50 terminals are connected to a minicomputer, which is then linked to the Department's mainframe computer systems, including MPACS and MMIS. Thus, office automation is not an isolated undertaking, but is a component of the larger data processing systems that handle the basic work of the agency.

Before automating any division's operations, a careful needs assessment is conducted in order to assess that division's particular needs. The system is then designed to meet these requirements and implemented so as to minimize any operational problems. Systems personnel remain available to assist the divisions in the operation of their office automation system, so that maximum productivity gains can be realized.

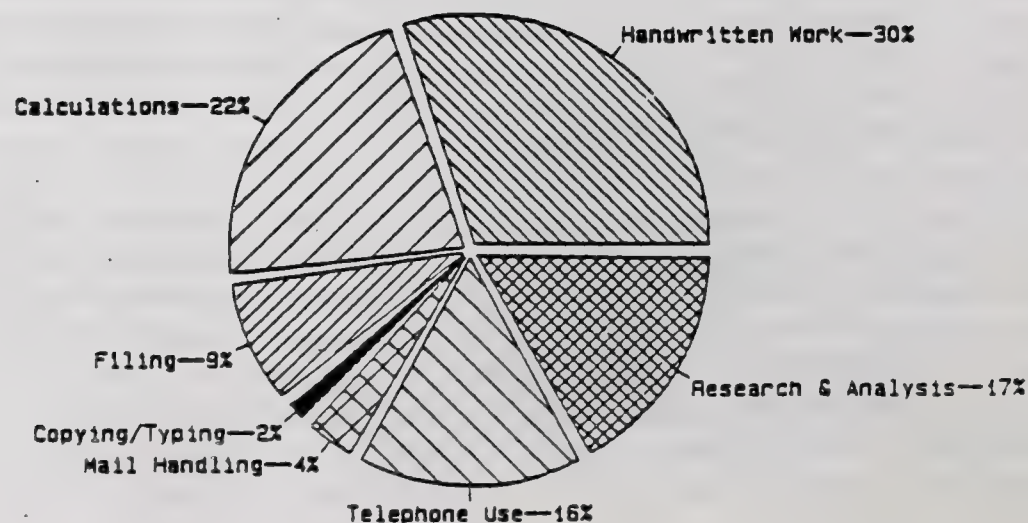
The major benefit of office automation is dramatic productivity improvement. Quantitative productivity improvements attributable to office automation include:

- o Providing the same level of service with fewer staff. For example, word processing allows production of the same level of correspondence and reports with fewer secretaries or typists. Studies have shown that word processing takes 50% less time than regular typing to accomplish routine tasks. Such improvements have allowed the Department to implement a staff reduction strategy which will result in 150 fewer staff in FY87 than in FY84.
- o Providing additional services or programs with existing staff. For example, with an automated tracking system, workers can monitor the progress and need of Project Good Health (PGH) recipients in order to improve their utilization of cost-effective preventive health care services.

In FY87, the Department will increase its FY86 savings and revenue goal of \$358 million by an additional \$70.5 million through several new savings and revenue initiatives. But the current manual routines for doing business stand in the way of realizing this ambitious goal. Department analyses have revealed that it is not uncommon for office units to spend 50% or more of their time on manual or handwritten tasks. By automating routine paper-based office tasks and providing word processing capabilities to draft and edit reports, office automation will allow managers to reorganize the work flow more productively so that agency goals can be realized without adding new staff. Managers will also be able to analyze, track and forecast trends and to use historical data to determine which strategies will most effectively produce the maximum savings and revenue.

The Third Party Recovery Unit of the Medical Division, the first division automated in FY86, provides a good example of office automation improvements. At any given time, a number of Medicaid recipients are actually insured by private, third party payers. Massachusetts has lagged behind other similar states in identifying claims where Medicaid has paid a claim but where a third party insurer should be paying the provider and in recovering the erroneous payment. The Massachusetts' recovery rate of 13% compares unfavorably with New York State's 32%, for example. One reason for this disappointing performance is that the Third Party Recovery Unit is bogged down in a paper intensive system. As the chart indicates, claims analysts can only spend 17% of their time on claims research and analysis activities which lead to collections. Nearly two-thirds of their time is taken up by written work, calculations and filing. An office automation system that included electronic calculation, database management and file maintenance will alleviate this paperwork burden. Claims analysts will be able to spend more time improving the recovery rate, which contributes to the realization of \$10.1 million in additional savings for FY87.

Task Analysis for Medicaid Third Party Recovery Unit



**Percentage of Claims Analysts'
Time Spent on Various Tasks**

Other cost savings attributable to Medicaid's office automation include:

- o The elimination of unnecessary claims processing by the Prior Approval Unit. Over 100,000 claims a year are currently processed twice. Automation would eliminate this duplication, saving \$40,000 to \$50,000.
- o The increase in the number of audits that can be performed by existing staff in the cost control units. Each additional audit has the potential of recouping \$10,000 to \$20,000 for the Department.

The Finance Division has also identified cost savings attributable to office automation. Automating the bookkeeping and document processing functions for collections units will allow those units to collect an additional \$4 million in FY86 and \$3 million in FY87. Managers will no longer have to spend their time managing paper, but will instead be able to concentrate on collections and reducing backlogs. For example, estate recovery, probably the largest untapped area of potential collections growth, is hampered by an unprocessed backlog of 2,000 liens. An automated accounts receivable system will relieve staff from dealing with the current mountain of notices, documents and checks, and allow them to spend time billing recipients for overpayments and establishing liens with courts.

Similar cost savings, increased revenues or new program initiatives will occur in other divisions as they are automated in FY87.

C. Comprehensive Matching System

A third FY87 initiative is the development and implementation of the State Income and Eligibility Verification System (SIEVS). This integrated computer matching system will allow prompt and accurate matching of the Department's eligibility database with insurers and financial institutions, the Internal Revenue Service (including unearned income data), the Social Security Administration, and state agencies, such as the Department of Revenue, the Division of Employment Security, and the Registry of Motor Vehicles. This will contribute to error rate reductions in the AFDC, Food Stamp and Medicaid programs. Coupled with the improved eligibility database provided by MPACS, this computer matching system will greatly expand the Department's ability to verify the income and asset information provided by recipients.

D. Automated Accounting System

Finally, during FY87, the Department will be participating in the development of the state's new comprehensive automated accounting system, the Massachusetts Management Accounting Reporting System or MMARS. This system will provide the timely information required for improved financial and management control through its on-line entry and editing capabilities. As a comprehensive system, it will

integrate the Department with the full range of the state's improved appropriation accounting system.

FY87 REQUEST

The Department's FY87 Systems request is \$4,361,999. Of this total, \$4,062,079 represents the continuation of FY86 activities. \$299,920 is requested to purchase the data processing equipment required to continue with the automation of central office divisions.

<u>Subsidiary</u>	<u>Component</u>	<u>FY87 Request</u>
(01)/(02)	<u>Personnel</u>	\$754,312

Personnel costs reflect funding for the legislative cap level of 25 FTE positions.

(03)	<u>Technical/Professional Services</u>	\$2,877,599
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In FY87, the Department is requesting \$2,877,599 in (03) contract funds for data processing services. All of this total represents a continuation and annualization of FY86 activities. No expansion is requested for FY87. The (03) subsidiary breaks down as follows:

o	Planning, Education and Office Automation Unit	\$447,691
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This unit supports the on-going planning and education activities of the System Division, which includes the two Information Centers in the Department's central office. This unit also provides the data processing services for office automation.

o	Administration	\$325,460
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This unit provides internal operations support for the Systems Division, such as contracts/procurement, word-processing and inventory maintenance.

o	Finance	\$408,371
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This unit provides data processing support for the Department's management support systems, including MIDAS and PMIS. It also provides systems support for the Finance Division's collections and savings initiatives.

o Eligibility Programs \$398,629

Eligibility determination for AFDC, Food Stamps, General Relief, Medicaid and Refugee Assistance programs is the central task in the administration and delivery of welfare benefits and services in the Department's local offices. This Systems unit provides data processing support for eligibility determination and re-determination. In FY87, it will also provide support for the development and implementation of the State Income and Eligibility Verification Systems (SIEVS).

o Systems and Programming \$814,992

This unit provides data processing support for the Department's major systems, such as the Financial Management and Control System (FMCS) and the Monthly Income Reporting System (MIRS). With the implementation of new systems such as MPACS during FY87, support staff can begin to be redeployed from this unit.

o Information and Network Services \$482,456

This unit provides a variety of maintenance services to ensure the integrity of the Department's data files and of the communications network linking the Department's local offices and central office to the state's mainframe computers in Boston. It also staffs the Help Desk. Increased demand for these services in FY87 because of MPACS implementation will be met through redeployment of existing resources.

(12) Maintenance and Repairs \$94,024

This subsidiary funds existing data processing service and maintenance contracts. It includes maintenance of office automation systems.

(15) Equipment Purchase \$299,920

This subsidiary reflects the FY87 installment purchase cost of the five year municipal lease purchase of data processing equipment for office automation systems in three divisions. This represents a continuation of FY86 activities, when the first divisions were automated.

(16) Equipment Rental \$336,144

In FY87, this subsidiary funds existing leases of data processing equipment. No expansion is requested.

TOTAL FY87 REQUEST

\$4,361,999

TRAINING (4400-1035)

	<u>FY84</u>	<u>FY85</u>	<u>FY86*</u>	<u>FY87 REQUEST</u>
Expenditures	\$609,966	\$588,468	--	\$1,738,947

In FY86, the training account was consolidated with the Management and Support Account. In FY87, the Department is requesting that a separate training account be re-established. With the implementation of the Massachusetts Public Assistance Control System (MPACS) in FY87, the delivery of services and benefits in the local offices, and thus the way in which workers perform their jobs will change substantially. These anticipated changes will require a substantial training effort that can best be managed by centralizing training funds and activities in a single account. In addition to the training that will be required by MPACS implementation, other on-going agency initiatives require training, including:

- o maintaining low error rates;
- o improving and increasing worker productivity;
- o improving service delivery to clients; and
- o increasing worker motivation and job satisfaction.

Achievement of these initiatives requires that the Department's direct service field staff, who interact with clients and administer assistance programs on a daily basis:

- o understand fully the policies governing the Department's assistance programs;
- o know the procedures required to provide these benefits; and
- o effectively communicate with clients in order to understand their circumstances and needs.

To ensure that accurate, timely, and compassionate services are delivered, training units are located in 22 of the Department's local offices. In addition, training centers are located in the Department's central office. The training staff works to ensure that new or changed

*Training account consolidated with Management and Support account (4400-1000).

policies and procedures are communicated to the workers who are responsible for accurately implementing them. The 18 central office training specialists:

- o develop training materials;
- o implement staff development programs; and
- o administer skills training programs.

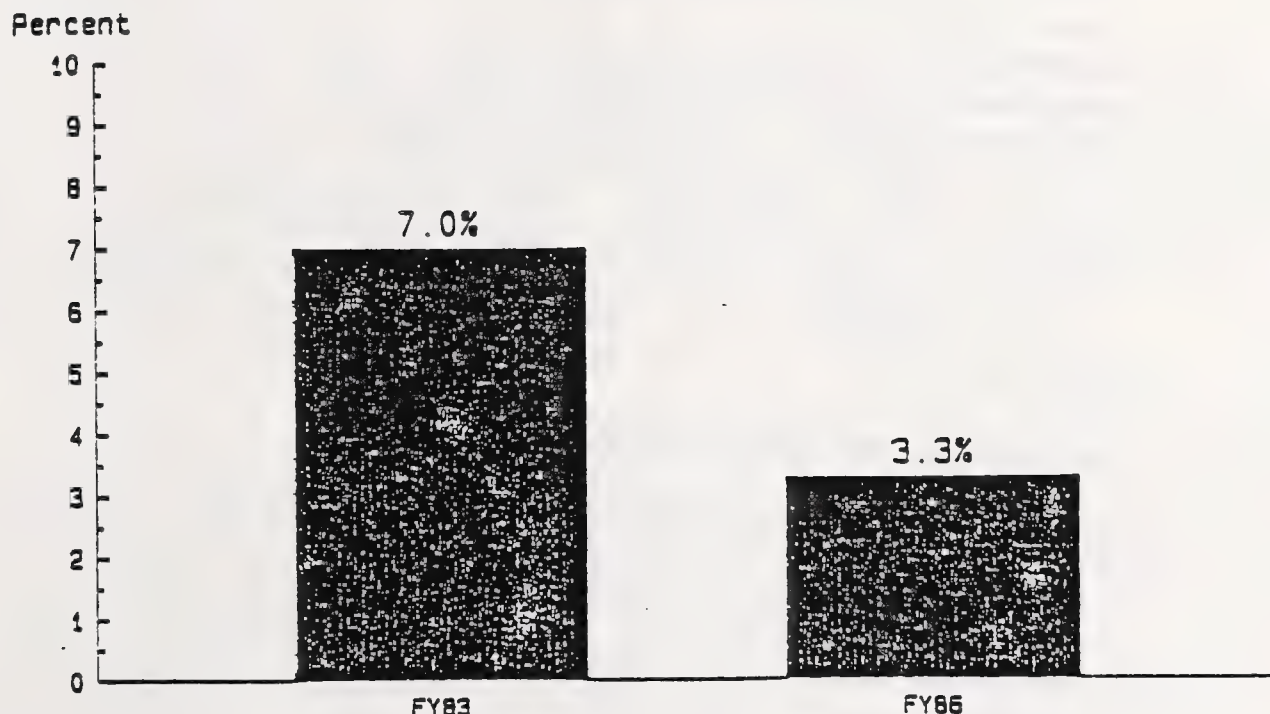
PERFORMANCE 1984 TO 1986

In FY85, the capacity of the training unit to provide comprehensive training became especially critical when the Department increased the number of direct service workers by more than 200. This increase in case-carrying staff reduced caseload to worker ratios to more manageable levels and was an essential feature of the Department's successful error reduction efforts. The features of this new training strategy to reduce error are described briefly below.

A. Error Rate Reduction through Improved Training of New Workers

The Department replaced traditional classroom training with an initial on-the-job training program in which new workers spend 3 months in a training unit managing a caseload under supervision. The Department was able to reduce error among new workers in this training unit from 7.0% in FY83 to 3.3% in FY86.

**AFDC Error Rates in Training Units
FY83 and FY86**



B. Managing the Training Pool - Anticipating Vacancies

In FY85, to maintain lower case to worker ratios, the Department began to maintain a pool of workers in training at all times. A pool of workers in training allows the Department to respond rapidly to turnover, vacations, and extended worker absences, and to maintain manageable case to worker ratios. The time required to fill a direct service vacancy now ranges from 1 to 14 days, down from 6 to 9 months in FY83.

C. Ongoing Skills Training Maintains Accuracy

Skills training, the largest component of spending in the training account, is designed to update and improve worker skills and to teach workers the new skills necessary to meet the Department's changing needs. In FY85, several training seminars were initiated, including:

- o a communications package designed to improve worker skills at listening, writing, and verbal expression;
- o effective interviewing techniques to enable workers to more accurately evaluate client circumstances and needs; and
- o service orientation training which encourages workers to be sensitive to clients' needs, rights, and cultural heritage.

In FY86, skills training was expanded to include:

- o clerical training

Although the Department maintains approximately 800 clerical staff in its field offices, little attention had been paid to increasing their role in improving local office accuracy and operations. In FY86, the Department began a clerical training program designed to upgrade clerical skills and to teach staff the Department's forms and procedures more fully. The clerical staff are now able to assume a more active role in local office operations, and Financial Assistance Social Workers are able to spend more time with clients reducing error, placing clients in ET programs, and making child support referrals. In FY87, the Department will provide all clerical staff with this training.

- o management and supervisory training

Even if Financial Assistance Social Workers and clerical staff are well-trained, the Department's efforts are severely hampered unless supervisors and management staff are equally well-trained. To this end, the Department expanded its retraining of all the Department's Financial Assistance Social Work Supervisors. Supervisors have become effective problem solvers, more responsive to the needs of direct service workers. In FY86, the Department also continues to

participate in management classes provided through a state management development program.

D. Data Entry Training Prevents Error

Recognizing the need to upgrade the computer skills of the Department's data processing and data entry staff to maintain accurate automated data files, steps were initiated in FY85 to develop in-house on-going computer training. This training has continued into FY86 with participation in:

- o external and internal seminars/conferences
- o courses offered on-site by outside vendors

The Department continues to enhance existing training to upgrade the skills of the data processing and entry staff in anticipation of the increased importance of data integrity and computer skills when MPACS is implemented.

STAFF DEVELOPMENT AND TRAINING

The purpose of the staff development and training unit is to contribute to the agency's goal of effective and professional administration of public assistance programs by maximizing the job skills of agency personnel. This broad initiative is accomplished by providing all levels of staff with training in specific skills, program policies and procedures, and the use and applications of the computer system. To better address the needs of new hires and the professional development of existing staff, on-going training is organized into the following components:

A. Initial Training

Before newly hired eligibility workers begin working in the field, they first participate in three months of intensive training in a training unit. During the first month, trainees are in the classroom learning AFDC, Medicaid, and Food Stamps policy and procedures. In the second and third months, trainees handle actual client cases and learn to handle more difficult problems and larger caseloads.

B. In-Service Training

In order to keep workers up-to-date concerning frequently changing policies and procedures, the Department runs an extensive program of in-service training. When complex policy changes occur, the Department's training staff organizes and delivers workshops across the state to explain the changes and to ensure that workers will be able to implement them accurately. Review seminars are conducted in error-related areas of policy and procedures as a critical part of a corrective action plan. The program also provides generic skills training for supervisors, FASW's, FASWT's, and clerical staff.

C. Management Development Training

Managers at all levels within the Department are offered the opportunity to participate in the Massachusetts State Agency Management Development Program, sponsored by the Department of Personnel Administration. This program provides management skills training specific to public service management, to managers from all agencies in the Commonwealth. In addition, management development groups, a series of monthly management support meetings providing managerial skills training, are offered to area and branch office management staff.

FY87 AGENDA

The implementation of MPACS will dominate the FY87 training agenda. In FY87, a substantial and broad-based effort will be made to focus on the re-training and professional development of the entire staff in anticipation of MPACS. With MPACS implementation, local office staff will be called on to incorporate computer skills into all facets of their work, learn the MPACS system, and manage client services and client outcomes. To do so effectively, the Department will upgrade the basic skills of clerical and direct service workers.

Training is an essential ingredient to successful MPACS implementation, and improved service and benefits delivery. The Department's success in using MPACS to improve service delivery depends ultimately on its use by workers in the local offices. These direct service workers, then, will be the target of the Department's proposed FY87 MPACS training initiatives. In fact, a survey of all local office workers indicates that training is considered by all staff to be, by far, the most important factor in preparing for MPACS implementation.

During FY86, a small staff of professional trainers will prepare for this next step of training by developing the MPACS training curriculum. They will then fully train the staff from the Department's training unit, who will, in turn, conduct training for all Department staff in FY87. The training curriculum will be modular, meaning that each worker will receive training germane to each area of his or her job responsibilities. Supervisors will be responsible for learning the modules that apply to their unit; local office directors will be responsible for learning all of the training modules. The MPACS training agenda will be the most ambitious training agenda undertaken in the history of the Department.

Funding for the actual development and delivery of this MPACS training to local office staff in FY87 has been requested in the MPACS account (4400-1016). The Department's 18 training staff members, however, described here and funded in the Training account, will deliver results of this training package to supervisors and directors in the local offices who will then train all Department employees.

FY87 REQUEST

The Department is requesting \$1,738,947 in the Training account for FY87. This is a significant increase over previous years, an investment in training which is essential in FY87 to make the transition to automated case management and MPACS successful.

<u>Subsidiary</u>	<u>Component</u>	<u>FY87 Request</u>
(02)	<u>Personnel</u>	\$560,547
Funds are requested in this subsidiary for 18 FTE positions.		
(10)	<u>Travel</u>	\$50,000
This subsidiary funds out-of-state travel, in-state travel at \$0.22/mile, and expenses, including gasoline, for state cars operated by the agency's training staff.		
(13)	<u>Special Supplies and Expenses</u>	\$1,100,400
Funds are requested for skills training programs, including:		
o Orientation and on-the-job training for all new local office line staff, central office clerical, supervisory and management staff		
o Management training programs, including DPA programs and other professional development seminars		
o Supervisory programs		
o Clerical in-service and professional development		
o FASW service delivery training		
o Culbreath-related skill development programs		
o Data-entry training		
(14)	<u>Office and Administrative Expenses</u>	\$28,000
This subsidiary funds miscellenous expenses incurred by the training office.		
TOTAL FY87 REQUEST		\$1,738,947

MANAGEMENT AND SUPPORT (4400-1000)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditures	\$83,403,637	\$28,049,897	\$29,300,000	\$38,066,792

The Management and Support account (4400-1000) is the primary funding source for most of the administrative costs necessary in running the agency's programs and services. These costs include central office staff, contract services, supplies, office equipment, postage, central office rent, telephones, and other operating expenses. Although the funds requested in this account constitute only 1.7% of the agency's total FY87 budget request, the level of funding in this account is nevertheless a critical determinant of the agency's ability to provide efficiently approximately \$1.9 billion in cash assistance and medical benefits to over half a million clients.

The Management and Support account funds:

- o support for specific initiatives on the agency's management agenda;
- o the core of the Department's basic management services and staff which support its programs; and
- o the operations of such divisions as Finance, with its \$40 million agenda of collections and recoupment in FY86.

The first of these areas provides support to division managers who are accountable for developing managerial, programmatic, error rate, and savings and revenue agendas necessary for achievement of the agency's goals.

The agency's ability to maintain and improve its performance is largely dependent on providing central office staff with sufficient resources, resources which are funded in the Management and Support account. The level of funding in this account therefore has a direct effect on the agency's performance. Over the past three years, adequate funding of central office staff and operating expenses has enabled the agency to:

- o reduce the AFDC and Medicaid error rates to the lowest levels in the agency's history.
- o achieve a record \$358 million in savings and revenue from FY83 to FY86.
- o maintain spending growth in the FY83 to FY86 period at an average of only 5% per year.

- o increase child support collections by nearly 13% over FY83 levels, from \$40.1 million to \$45.1 million in FY85, with a further increase to \$50.0 million projected for FY86.

In FY87, the agency is requesting that funds from the general Contract Operations account (4400-0900)--established in FY85--be distributed among the Management and Support and other accounts. The agency is requesting that specific contract funds be appropriated within these accounts because these funds directly support the statutory and management purpose of each account. Providing a single funding source for the purposes of each area of operations, incorporating both contract and other management funding, is consistent with the nature of the agency's operations and its account structure, and allows performance of various programmatic and administrative goals to be measured against a single management funding resource. Furthermore, creating this direct relationship between resource and purpose will enable the agency to improve the accountability of its managers for attainment of specific goals.

MANAGEMENT PERFORMANCE 1983 - 1986

Management initiatives funded through this account have enabled the agency to control spending and improve savings and revenue efforts such that the overall agency budget over the last five years increased by an average of only 4% each year--lower than the Boston Consumer Price Index for this period and significantly lower than spending growth rates for the rest of state government. These agency-wide savings and revenue efforts are discussed in part below, and are explained in greater detail in a separate volume accompanying this narrative. In addition, initiatives funded through this account have included other management improvements such as specific administrative savings steps, essential central office space improvements, and savings and improvements in client service due to modern phone systems. Each of these initiatives is described briefly in the following pages.

A. Support for Savings and Revenue Agenda

The Department's annual savings and revenue agenda is comprised of four areas: Medicaid, Child Support, Finance, and ET. Each year, managers in these four areas must develop and implement a series of initiatives which will result in savings and revenue for the Department. The Management and Support account funds a portion of the Medicaid, Child Support and ET initiatives and provides most of the resources for Finance collections.

o Finance Collections

The Finance division maintains a \$40 million agenda in FY86 of initiatives designed to collect overpayments and payments from third parties to reimburse the Department for expenses it has made on behalf of clients. Since FY83, total Finance collections have increased significantly. The Finance division expects to collect over \$40 million in FY86 and more than \$50 million in FY87, an increase of \$30 million over FY83 levels.

The primary sources for these overpayments include: Medicaid providers who receive retroactive rate decreases; casualty insurers representing clients who received benefits because of an accident; the estates of clients over age 65 who improperly received benefits; clients who received retroactive Supplemental Security Income (SSI) benefits while receiving concurrent General Relief benefits; and clients who make restitution for welfare fraud. Fraud accounts for 10 to 15% of collections, while providers and third party payors provide the main target for revenue growth.

Finance's initiatives in recovering these payments have concentrated on identifying untapped sources of revenue, reducing backlogs, automating document processing functions, and automating accounts receivable. This effort has also involved important cooperation with other agencies, including the Rate Setting Commission, Industrial Accident Board, Bureau of Special Investigations, and state court probation departments.

There are four units in the Finance division that are responsible for collection activities:

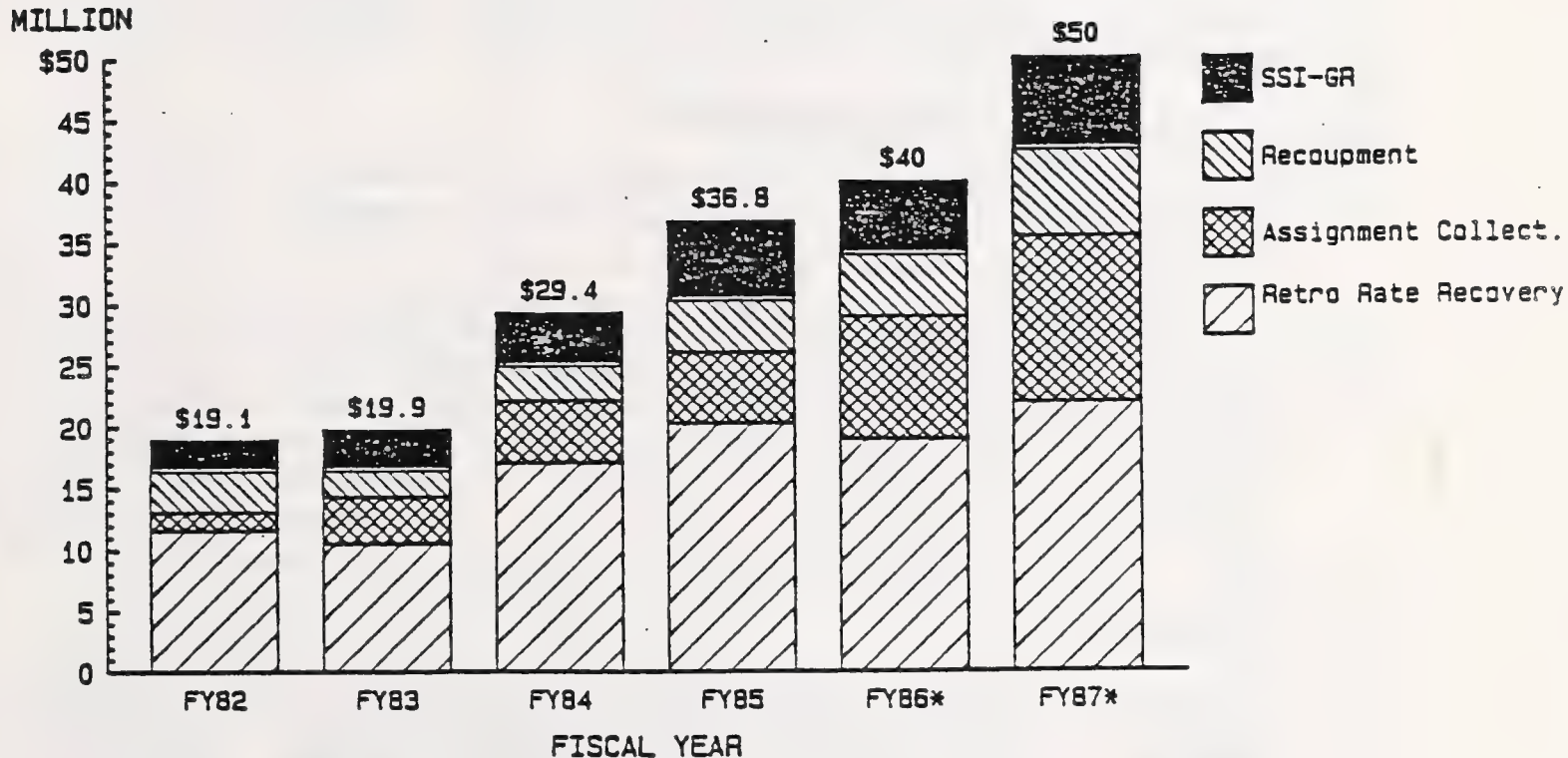
- Retro-Rate Recoveries Unit - This unit collects overpayments to Medicaid providers. These overpayments occur when an interim rate for Medicaid services, which is used pending settlement of a final rate, is lower than the actual final rate. This overpayment is usually recouped by offsetting current or retroactive payments to the provider. Timely and efficient processing of rate changes and improved communications with the Rate Setting Commission have helped to produce a 92% increase in retro-rate recoveries from \$10.6 million in FY83 to \$20.3 million in FY85.
- Assignment Collections Unit - When an individual eligible for public assistance is able to recover money because of an accident, often through workman's compensation, the Department takes a lien on the potential recovery. This lien, established by a local office social worker, is forwarded to the Assignment Collections Unit, which is responsible for tracking the claim, negotiating with attorneys, and collecting any money recovered up to the amount of the assistance provided to the recipient. Due to initiatives which include focusing on cases with the best cost-benefit ratio, this unit has increased collections from \$3.8 million in FY83 to \$5.8 million in FY86.
- Centralized Recoupment Unit - This unit is responsible for the collection of overpayments to AFDC, GR, Medicaid and Food Stamp recipients. This collection can be made either by direct payment from the client or by offsetting current payments by a limited amount. Through establishment of an offset and disqualifications system to recoup Food Stamps

overpayments, this unit has been able to double collections from \$2.1 million in FY83 to \$4.2 million in FY85, thereby avoiding \$1.2 million in federal sanctions.

- SSI/GR - When a General Relief recipient is retroactively approved for SSI, the Social Security Administration sends the retroactive check to this unit, which then determines the amount of GR assistance given the client during the period covered by the SSI approval. This amount is deducted from the SSI check and the balance is forwarded to the recipient. Between FY83 and FY85, the SSI/GR unit increased collections by 91%, from \$3.4 million to \$6.5 million.

As the accompanying chart illustrates, these improvements in the Department's collection efforts have increased total Finance collections by \$17 million, or 85%, from FY83 to FY85. It is projected that additional efforts, including a centralized automated recovery system which will computerize 15,000 manual records, will continue to produce additional revenue, with projected collections increasing to \$40 million in FY86 and to \$50 million in FY87.

FINANCE COLLECTIONS FY82-FY87



*projected

B. Administrative Savings

During the last two years, the Department has initiated a number of changes in the area of administrative spending that have significantly improved its ability to manage and reduce administrative expenses.

In FY85, the Department established budgets for each of its fifteen divisions as a means of both establishing a level of funding necessary to support a division's goals, and creating a mechanism to control administrative spending in a number of subsidiaries.

Second, in FY86, the Department will implement a system to control administrative spending on office supplies. In FY85, the Department analyzed spending on supplies and determined an average ratio of supply costs per employee. Beginning in FY86 and continuing into FY87, the Department will initiate procedural changes to ensure that all local offices and central office divisions control spending on supplies at a level consistent with this ratio.

Third, in FY85, the Department also began to improve the quality of its local office phone systems. As described later in this section, the replacement of old and inefficient phone systems with new systems acquired through lease-purchase agreements saves the agency nearly \$4 in rental costs for each phone replaced. In FY86, the Department is planning to install twelve new phone systems, including a new central office system at 600 Washington Street, which will reduce the Department's phone costs in FY87 by nearly \$300,000. In FY87 the Department expects to replace an additional ten phone systems.

C. Central Office Space Improvements

For thirty-five years, the Department's central office has been located at 600 Washington Street. For a number of years, staff at 600 Washington Street have worked under extremely poor conditions. Previous landlords did not provide adequate maintenance, emergency lighting did not operate, the building's heating and cooling system was antiquated, the elevators failed inspection, the lighting was inferior, rodent infestation was a continual problem, and no accessibility for the handicapped was provided. For more than fifteen years, the building received no significant renovation work, and the attendant poor and unsafe work environment has had a tremendously negative effect on employee motivation, morale and productivity.

In FY84, therefore, working with the Division of Capital Planning and Operations, the Department began a plan to move a portion of its central office staff out of 600 Washington Street. A year and a half later, much of the central office staff moved into 180 Tremont Street -- a newly renovated building located one block from 600 Washington St. -- and occupied professional office space that has significantly improved the attitude and productivity of central office staff. In addition, in FY86, the Department has initiated renovation plans for

600 Washington Street which will culminate in a complete renovation of four floors of office space during the first quarter of FY87.

D. Office Equipment

The Department's local offices have a long history of operating with inadequate and outdated office equipment. Equipment surveys conducted in the past by the Department have revealed:

- o local offices which received no new equipment for three years, despite significant changes in staffing levels;
- o 7 staff without desks in the Springfield office;
- o a conference room in the Palmer office with no furniture; and
- o no chairs for reception areas and staff in the Brockton, Fitchburg, Malden, and Quincy local offices.

The absence of such essential equipment not only constrains productivity, but also prevents workers from performing such vital functions as interviewing clients and redetermining eligibility. Inadequate resources for equipment thus had a direct and adverse effect on the Department's efforts to both reduce error rates and improve service delivery to clients.

In FY85, therefore, the Department made providing modern office equipment for local and central office staff a priority. New desks, chairs, typewriters, tables, and bookcases were ordered and delivered to the Department's local and central offices. This new equipment helped to create a more professional environment for local and central office workers. More importantly, the Department noticed that worker morale, accuracy and productivity improved as a result of these new resources, as did the attitude of clients toward the Department.

The Department will continue to improve the condition of local and central office equipment in FY86 and FY87. Further, MPACS implementation in FY87 will necessitate replacing old and dilapidated equipment with new equipment that can accommodate MPACS hardware.

E. Telephone Systems

In FY85, the Department began a major effort to improve the quality of its local office phone systems. A survey conducted at the beginning of FY85 determined that almost two-thirds of the local office phone systems were outdated, inflexible and costly to maintain. The Springfield office phone system, for example, would not accept any incoming calls when all phones were in use -- clients would instead hear a continuous ring. To change the location of one phone in a local office would require the Department to place a work order with the phone company, incur a service charge, and pay for cabling to be removed and relocated. New phone system technology allows phones to be easily unplugged and moved to another outlet for

relocation. Replacement of these old, expensive systems contributes towards improving worker productivity, as well as controlling future costs.

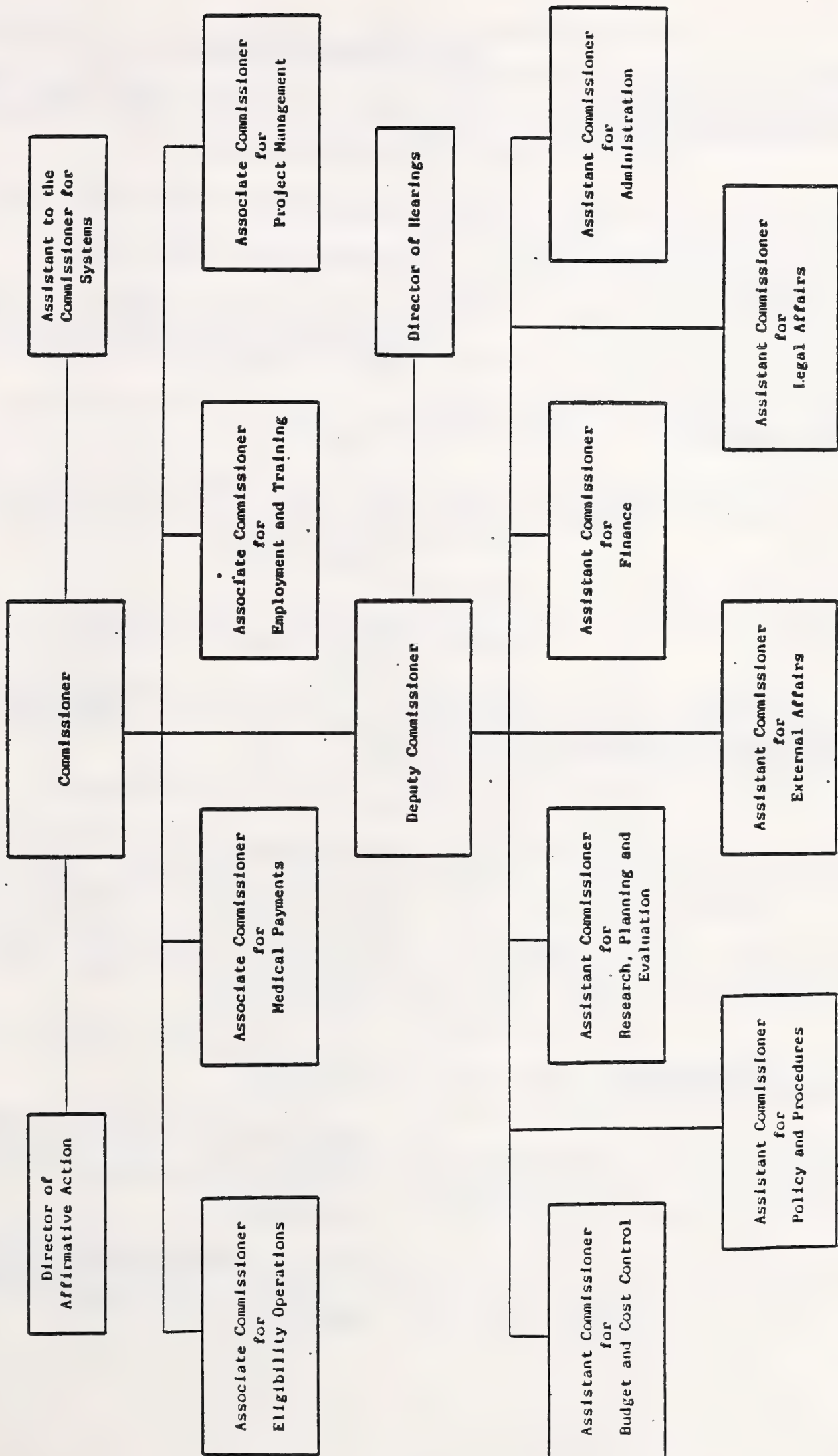
In FY85, five new phone systems were installed, including a new central office system at 180 Tremont Street. Twelve new systems are to be installed in FY86, including a new central office system at 600 Washington Street.

The Department is expecting to replace ten local office phone systems in FY87. At a cost of \$220,000 in FY87, these new systems will replace old key telephones now located in local offices. These new systems will allow the Department to replace the thick cabling which is required for key telephones, and is costly to install, with wall jacks that allow phones to be unplugged and relocated within an office at no additional cost to the Department. These new systems will also be acquired through lease-purchase agreements, as opposed to the rental agreements through which most of the Department's phones are currently obtained. Lease-purchasing of phones saves the Commonwealth approximately \$4 for every phone currently being rented. It is projected that the Department will avoid nearly \$300,000 in rental and maintenance costs for phones in FY87 as a result of these installations.

MANAGEMENT OF THE AGENCY

Central office staff, partly funded in the Management and Support account, are located within fourteen divisions and the offices of the Commissioner and Deputy Commissioner.

These divisions and their primary FY87 responsibilities are listed on the pages following the agency organizational chart.



Division

FY87 Responsibilities

Eligibility Operations

- o eligibility determination and client services for all cash and medical assistance programs
- o managing 69 area and local offices
- o maintaining low error rates
- o preparing local office for MPACS implementation and planning for using MPACS to improve case management

Medical Payments

- o achieving of \$40 million in new savings
- o improving access to health care, especially through implementation of Health Choices for families and children
- o improving the quality and cost-effectiveness of services for the elderly

Employment and Training

- o placing of 10,000 recipients into jobs
- o \$20 million in ET savings
- o improving and expanding the system of education, training, and supported work in order to broaden the range and quality of opportunities available to recipients, especially harder-to-serve clients with basic literacy needs

Project Management

- o \$56.3 million in child support collections
- o developing and managing programs for refugees and a state-wide system of 61 shelters and related services for the homeless
- o measuring the error rate performance of local offices and preparing corrective action plans

Division

FY87 Responsibilities

Systems

- o managing the statewide implementation and operation of MPACS while continuing to operate the agency's current eligibility systems
- o overseeing processing of 19 million Medical claims, and enhancing MMIS, the Medicaid Management Information System, which saved \$56 million in its first twelve months of operation
- o operating and enhancing the Department's management systems, including MIDAS (being replaced by MMARS), PMIS, SSPS
- o design and implementation of office automation systems for central office divisions
- o operation of a data processing information center for Department managers.

External Affairs

- o monitoring federal legislative and regulatory actions affecting Department programs, and securing continued WIN funding for the Employment and Training program
- o assisting in securing federal financial participation, including MPACS federal reimbursement
- o coordinating marketing and outreach efforts for the agency's programs and services -- ET, PGH, Child Support, Health Choices
- o coordinating activities of the Advisory Board network
- o developing local office audiovisual communications to inform clients of the agency's programs and services

Research, Planning and Evaluation

- o evaluating the effectiveness of Department programs

Division

FY87 Responsibilities

Evaluation (cont.)

- o producing monthly reports analyzing Department's productivity and management performance
- o researching recipient characteristics and problems in order to improve the adequacy and cost-effectiveness of Department programs
- o staffing projects and analyses in order to solve specific agency management problems

Finance

- o \$50 million in collections and revenue recovery, primarily through recoupment of overpayments to providers and recipients
- o auditing Department contracts
- o disbursing and accounting for Department appropriations
- o managing implementation of Executive Order 237, which mandates that the agency make 5% of applicable goods and services purchases from minority businesses
- o claiming federal reimbursement totalling \$947.7 million on programs and operating expenditures, and seeking to collect additional federal reimbursement through specific initiatives, including contesting disallowances

Administration

- o managing on-going training programs, including preparing for MPACS implementation
- o retrofitting all local offices in preparation for MPACS implementation
- o developing and maintaining a personnel information and recruiting system, and maintaining staffing levels in local offices

Division

FY87 Responsibilities

Administration (cont.)

- o developing methods to evaluate and assess all factors of work design, including providing work simplification strategies
- o managing agency payroll, office space, printing, equipment, supply and other support activities
- o monitoring the progress of agency divisions in reducing central office staffing

Budget and Cost Control

- o preparing and explaining the agency's budget request and spending plans
- o managing a system of operating budgets for agency divisions and programs
- o developing, monitoring, and analyzing agency savings and revenue initiatives
- o monitoring and analyzing of operating expenditures, program spending, and caseload trends

Policy

- o drafting policy and procedures in response to agency, legislative, and federal mandates
- o developing an on-line capability to draft and revise policy manuals for MPACS
- o providing on-going procedural support for MPACS operation
- o handling policy disputes with federal funding agencies

Legal

- o legal work critical to achievement of Child Support and Finance collections targets and Medicaid savings
- o reviewing all proposed Department policy and contracts for compliance with state and federal regulations

Division

FY87 Responsibilities

Legal (cont.)

- o coordinating the implementation of court decrees, and, in cooperation with the Attorney General's Office, representing the Department in all litigation
- o contesting federal reimbursement disallowances

Hearings

- o providing applicants and recipients with fair hearings, in accordance with state and federal regulations

Affirmative Action

- o achieving affirmative action goals, as determined by the State Office of Affirmative Action.

FY87 AGENDA

Funds for several management initiatives and improvements are requested in the Management and Support account in FY87. These include the following:

A. Office Automation

Although office automation is primarily funded out of the Systems account (4400-1010), funding for the Administration division's office automation system is requested in the Management and Support account. The first phase of this system will be implemented in the latter part of FY86 and the second phase will be finished in early FY87. The agency is requesting \$150,000 in FY87 to complete this system.

Automating the Administration division will significantly improve productivity, enabling the division to:

- o provide the same level of service with fewer staff;
- o provide additional services or programs with existing staff;
- o reduce paperwork; and
- o Provide automated tracking of resources, projects and work flow.

Automating the agency's payroll system under the state's new computerized Personnel Management Information System (PMIS) has already significantly improved the operations of the Administration division -- reducing staffing in the Personnel and Payroll Unit by 75% and eliminating manual tracking of employee personnel transactions.

In FY86, the Hearings Division will complete a two and a half year project to implement a fully automated data base computer system. This system will maintain all decision records, thereby enabling the Hearings division to:

- o monitor patterns of activity, including the number and type of appeals in a given area or office, and the decisions rendered.
- o compare these results to such variables as the frequency of Department legal representation, and success levels of various offices, by type of appeal.
- o provide periodic reports using accurate statistical data to the federal government.
- o identify appeals trends in order to efficiently deploy available staff resources.

Final implementation of this system in FY86 will improve dramatically the productivity and efficiency of this division, as well as improve the division's ability to reduce staff in FY87.

B. 600 Washington Street

In FY87, the Department will complete the renovation process, initiated in FY84, of its central office space. As mentioned earlier, the Department moved a portion of its central office staff to new space at 180 Tremont Street at the end of FY85. Renovation plans were initiated in early FY86 for the space still occupied by the central office staff remaining at 600 Washington Street. These plans include replacement of electrical ducts, installation of new wiring, subflooring, fire proofing, perimeter, office and ceiling framing, lighting, and elevator repairs. It is anticipated that work will be completed during the first quarter of FY87, at which time the Finance, Hearings, Medicaid, and portions of the Systems and Project Management divisions, will occupy new, professional office space.

FY87 REQUEST

In FY87, the Department is requesting a total of \$38,066,792 for the Management and Support account.

The request is described below by subsidiary:

<u>Subsidiary</u>	<u>Component</u>	<u>FY87 Request</u>
(01)	<u>Personnel</u>	\$9,206,710
Funds are requested for 414 FTE positions.		
(02)	<u>Personnel</u>	\$6,971,595
Funds are requested for 229 FTE positions.		
(03)	<u>Contract Services</u>	\$7,849,592
This subsidiary funds essential contract services which include: security and building maintenance for the agency's local and central offices, temporary clerical assistance, auditing of contractors and vendors, error rate analysis, student interns, translators, and incidental administrative services, and specialized staffing for six divisions.		
(06)	<u>Housekeeping Supplies and Expenses</u>	\$39,158
Housekeeping supplies for all local and central offices are funded in this subsidiary.		
(08)	<u>Heat and Other Plant Operations</u>	\$1,433,371
Fuel oil, gas, electricity, and water expenses for the local and central offices are funded in this subsidiary.		
(10)	<u>Travel and Automotive Expenses</u>	\$399,316

This subsidiary funds out-of-state travel, reimbursement for in-state travel at \$.22/mile, and expenses, including gasoline, for state cars operated by the agency.

(11) Advertising and Printing \$313,584

Advertising expenditures, including legal, office space and personnel advertisements, are funded in this subsidiary. All printing performed by outside services, including blueprints, photostats, binding, and paper costs, are also funded in this subsidiary.

(12) Maintenance, Repairs and Services \$232,100

This subsidiary funds maintenance and repairs for local office and central office equipment, as well as automotive repairs for the truck that the agency rents.

(13) Special Supplies and Expenses \$338,090

Expenses for moving, damage claims, evidence, and special supplies are funded in this subsidiary.

(14) Office and Administrative Expenses \$5,818,253

This subsidiary funds a number of central office expenses, including postage, stationery, conferences, office supplies, freight, and paper. The reduction in FY87 telephone costs from FY85 spending is due to the lower cost of lease purchasing telephone systems for several local offices rather than renting systems. This subsidiary also funds paper and supplies for the agency's printing facility.

(15) Equipment \$536,422

This subsidiary funds furniture and office equipment for the central and local offices as well as the final phase of office automation for the Department's Administration division.

(16) Rentals \$4,928,601

Equipment rentals and central office space at 180 Tremont, 600 Washington and the Department's printing facility are funded in this subsidiary.

Total FY87 Request \$38,066,792

CHILD SUPPORT ENFORCEMENT (4400-1004/4400-1014)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 Request</u>
Expenditures				
(4400-1004)	\$4,695,316	\$6,639,281	\$6,982,794*	\$8,821,251
(4400-1014)	- -	- -	1,000,000	1,457,000
Collections	43,474,976	45,115,203	50,000,000	56,300,000

INTRODUCTION

Child support is the financial assistance required of an absent parent to help support his or her children.

In Massachusetts, nearly 92% of approximately 84,000 families currently receiving AFDC benefits are eligible because of the continued absence of one of the parents for reasons other than incarceration or death. If absent parents contributed regularly to family finances, these families could decrease or possibly end their dependency on public assistance.

Massachusetts established the Child Support Enforcement Unit (CSEU) in 1970 to offer a more comprehensive solution to the growing problems of single-parent families. In 1975, Congress established the Child Support Enforcement (CSE) program as Part D of Title IV of the Social Security Act. The IV-D program helps to strengthen families and reduce welfare spending by placing the responsibility for children where it belongs; on parents. According to the Census Bureau, in 1981, more than 8.4 million American women were raising children alone. Thirty percent of these women and children were living in poverty. In Massachusetts, in FY85, there were approximately 137,140 single parent families with annual incomes below \$10,000.

Over 30% of the children on the current AFDC caseload are born to unmarried parents. Clearly, there exists a large number of families who turn to the Department for help only because one parent, usually the father, is not fulfilling a legal and moral obligation to support his children.

In these situations, cash assistance (in the form of a grant) offers only limited and short-term relief. It does not provide a solution to the fundamental economic circumstances which a single parent faces. Since the poverty rate for single parent families is more than three times that of other families, the absence of a parent means a dangerously lower standard of living for the family. Experience shows that child support payments alone, while usually insufficient to remove a family from poverty, are an important component of long-term economic independence.

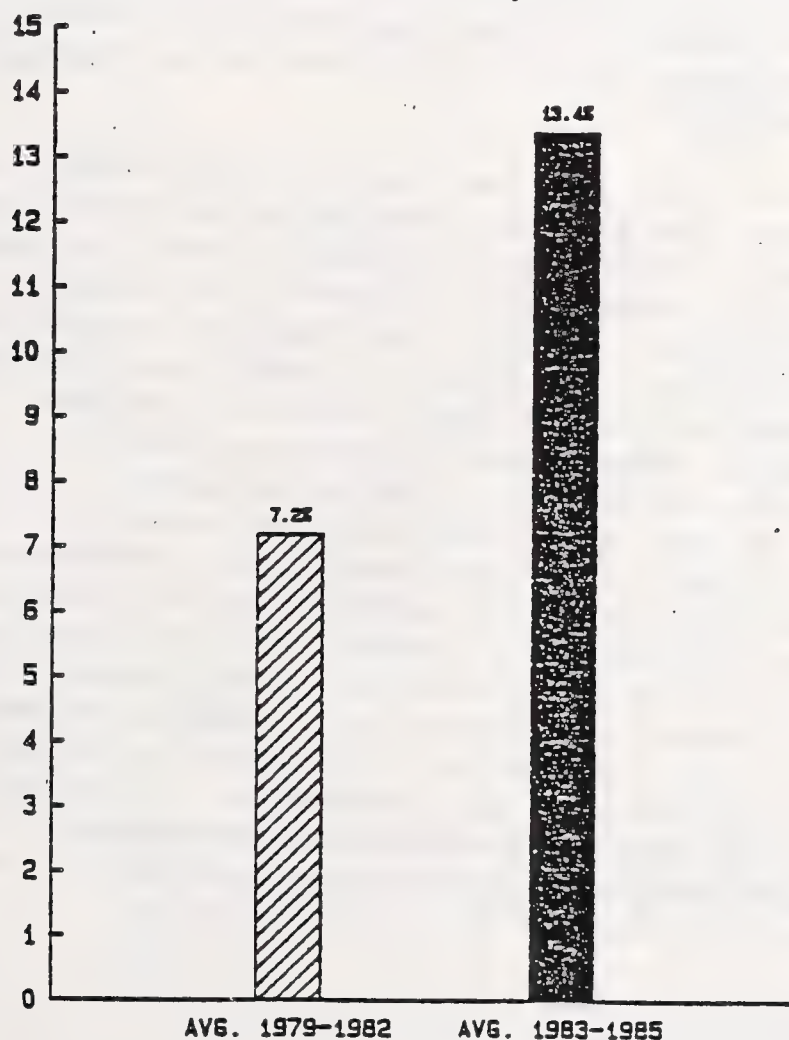
In order to overcome these problems, the CSEU, in cooperation with the state's judicial system, helps single parents to locate absent parents.

*Includes \$460,180 from Child Support Special Projects account.

establish paternity, obtain child support orders and enforce payment. These child support activities are also an important way to offset the state's AFDC costs. Recognizing that child support payments are frequently inadequate or sporadic, the Department provides custodial parents (usually the mother with custody) who do not have regular support with a full AFDC grant. The AFDC recipient assigns the right to child support payments to the Department, which then seeks to collect the support owed. As a result of 1983 state legislation, these child support payments are used to directly offset AFDC expenditures.

MASSACHUSETTS CHILD SUPPORT COLLECTIONS

% of AFDC Expenditures recovered by CSEU



Rising divorce and illegitimacy rates cause the number of single-parent families to grow each year. As a result, the state is faced with the potential cost of providing financial aid to an increasing number of single-parent families each year. In order to meet the collection goal of \$56.3 million and to provide services critical to long-term economic self-sufficiency to a growing population, the Department is requesting \$10.3 million to fund child support enforcement activities. The Department plans to increase its collections by almost 13% by implementing a more cost-effective method for child support by centralizing collections and expanding its performance-based contracts with the courts, sheriffs and district attorneys.

CSEU PERFORMANCE 1983 - 1986

A. AFDC Caseload Down/Collections Up

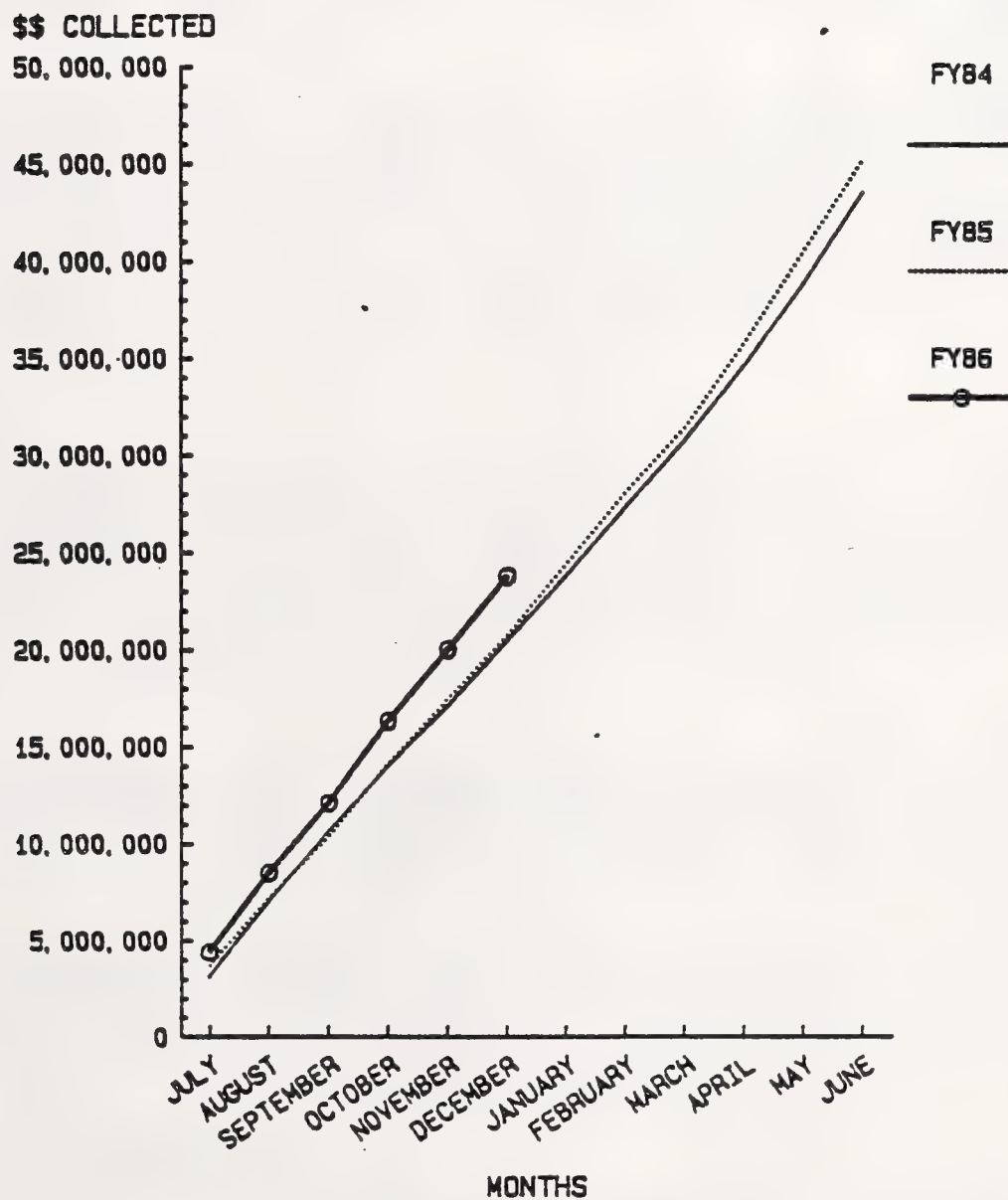
Approximately 90% of AFDC clients are referred to the CSEU for the purpose of locating absent parents, establishing orders and enforcing payment. During FY85, the AFDC caseload declined 3.5%, thus reducing the number of potential CSEU referrals. However, child support collections increased 3.6% in FY85 over the previous fiscal year to a record \$45.1 million.

Until FY82, the AFDC caseload had been increasing at a substantial rate each year. The increase resulted in a relatively high volume of CSEU referrals. Therefore, the CSEU focused its resources on cases that were easily processed. However, the passage of the Omnibus Budget Reconciliation Act in FY82 resulted in the implementation of new AFDC policy that initiated a significant decline in the AFDC caseload. This decline has continued over the last few years because of the healthy Massachusetts economy and the success of the Department's Employment and Training program. As a consequence of the decline of the AFDC caseload, new referrals to the CSEU have decreased. On the other hand, many cases where absent parents were delinquent in their payments remained on the caseload. In addition, the caseload included a number of cases without established paternity, which meant that the absent parents were harder to identify and locate and required more court involvement. Instead of depending on new referrals, the CSEU has had to refocus its activities and develop new strategies to ensure that the absent parents who had previously eluded the Department's efforts fulfilled their financial responsibility to their children. Partly as a result of the new strategies:

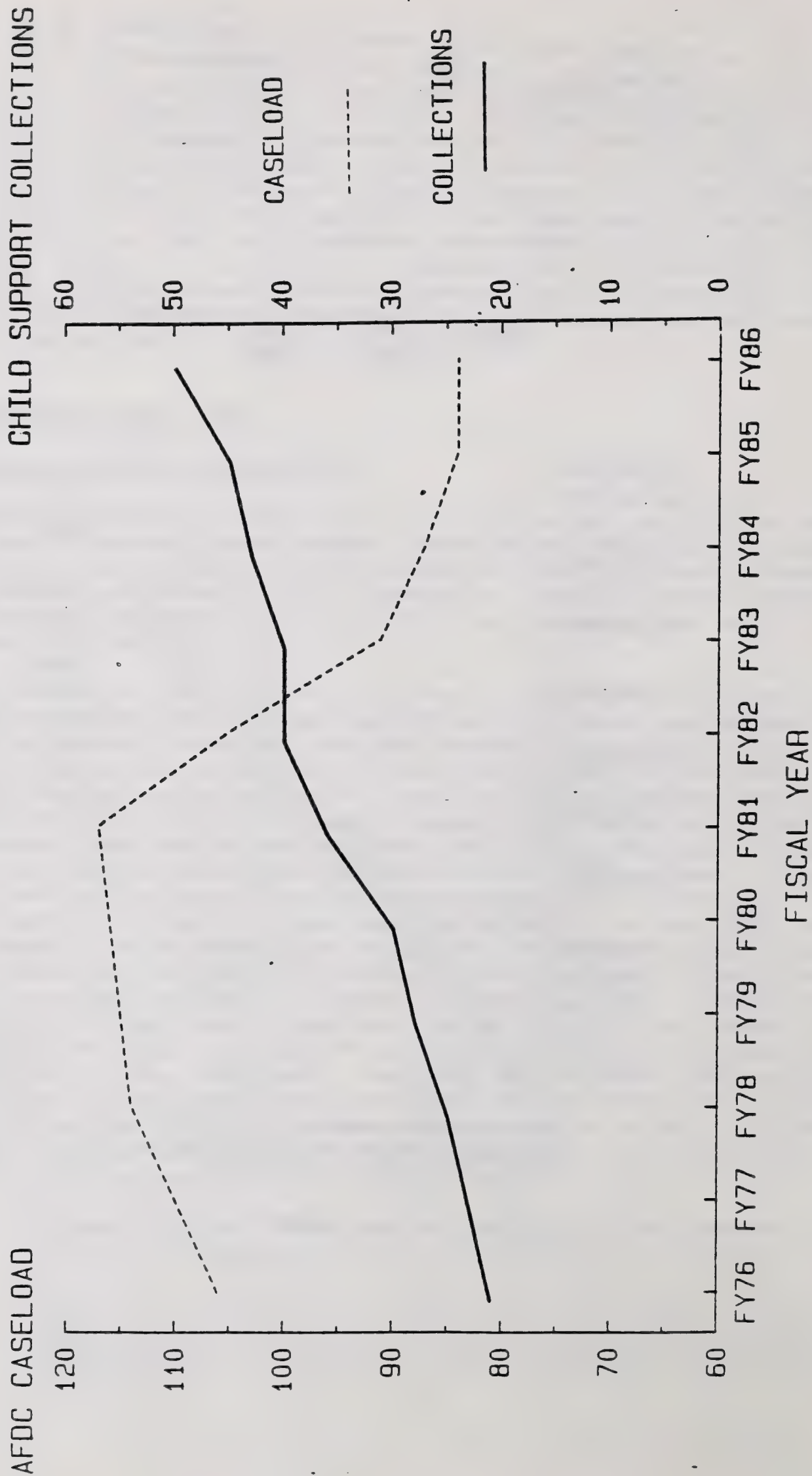
- o Between FY83 and FY86, the CSEU achieved a 25% increase in collections despite an 8% decrease in the AFDC caseload.
- o Since the strengthening of the state wage assignment law in 1983, the number of established wage assignments has been increasing, with a total of 15,000 wage assignments ordered through FY85.

- o Through FY85, there were 80,600 established child support obligations. In FY85, the CSEU established 12,471 new child support orders.

CHILD SUPPORT COLLECTIONS FY84 - FY86



AFDC CASELOAD VS. CHILD SUPPORT COLLECTIONS FY76 - FY86



caseload in thousands of cases
collections in millions of \$'s

Through the development of these and other strategies in FY86, the CSEU projects collections will reach \$50 million, an increase of 11% above the FY85 collections and 24.6% over FY83. Through the first half of FY86, the Department's performance has been strong. Child support collections for the first six months are nearly \$24 million. This is 14% ahead of FY85's record collection pace.

In addition, CSEU will realize an additional \$7 million in savings in FY86 through a combination of aggressive third party resource identification and timely case closings.

B. IRS/DoR Intercepts

Both federal and state tax intercept programs have been in effect in Massachusetts since 1982. These programs permit the CSEU to intercept an absent parent's tax refunds and to apply the refund to his child support debt.

In FY86, the CSEU has submitted 22,500 certified names (absent parents who are at least 90 days in arrears of their support obligations) for the federal tax intercept program. This represents a 13% increase over the tax number of names submitted during FY85. This program is projected to yield \$3.5 million in collections during FY86. That will bring the total collections from tax intercepts since FY84 to \$10.0 million.

C. Savings

Child support collections are an important way of offsetting the state's AFDC costs. However, the CSEU provides additional savings to the Department through child support-related case closings and third party health insurance referrals. In FY85, the Department established a savings goal for the CSEU for the first time. In FY86, the child support savings goal is \$7 million.

- o Case Savings: In FY85, savings from case closings alone equalled \$2.9 million. This savings amount is determined by the number of cases which close or grants which are reduced, usually because child support payments exceed the amount of the AFDC grant.
- o Third Party Liability (TPL): In FY85, CSEU was responsible for \$2.8 million in TPL Medicaid savings through identifying clients with access to private health insurance, often through the absent parent.

D. \$50 AFDC Disregard

As a result of 1984 federal legislation, the Deficit Reduction Act (DEFRA), the Department was able to return first \$50 in child support collected each month directly to the family, without being counted as income for purposes of AFDC eligibility. This \$50 disregard is an incentive to encourage custodial parents to fully cooperate with the CSEU in establishing support orders. The CSEU began distributing this incentive payment in March 1985 (retroactive to October 1984)

and custodial parents received \$5.9 million in payments in FY85. In FY86 the Department expects to distribute \$9.6 million in disregard payments.

FY86/FY87 MANAGEMENT INITIATIVES

Through the implementation of key management initiatives and the development of additional strategies in FY86, the CSEU projects that collections will reach \$50 million. The keys to improved collections are the Westboro DoR project; local office performance and management accountability; State Street Bank project (Lockbox); and court initiatives.

o Westboro/DoR

The CSEU is producing a tape-to-tape match of cases with DoR wage information files in order to identify those open AFDC child support orders from probate and district courts that, because of significant changes in absent parents' income should be resubmitted to obtain a higher order. The Westboro data processing unit sends these reports to the field to determine if either a modification or a contempt action should be filed in court.

During the first phase of the project, completed early in FY86, three probate courts were targeted. A total of 7,435 open and closed AFDC cases with child support orders were submitted to DoR to determine if there had been significant changes in the absent parents' income. DoR, in turn, provided the Department with 4,684 wage reports from absent parent employers. These were distributed to the CSEU local offices for review. Preliminary reports indicate that 17% of the 4,684 wage report cases will result in increases on established support orders and private health care insurance coverage.

The project is currently in its second phase. During this phase, 58,000 employers have been identified by DoR as possessing wage information on absent parents, which can be used by local office staff to determine if a higher support order should be sought, based on a change in the income of the absent parent.

In addition, CSEU has made agreements with the district and probate courts to ensure that these cases, when brought before them, receive high priority. These efforts will be expanded throughout this fiscal year and during FY87.

o Local Office Accountability

A key to increased local office collections is a system of district manager accountability for performance. In FY85, the Department established a child support organizational structure which featured district manager responsibility for the savings and collection performance of groups of local offices. Offices which temporarily fall behind in their goals are promptly identified so that district managers can work with local office staff to implement solutions.

As part of this system of local office accountability, CSEU managers have devised a case prioritization system which identifies and prioritizes during intake cases with the highest collection potential.

o "Lockbox" -- State Street Project

During FY86, the goal of the CSEU is to establish an on-line accounts receivable information system which will enable the Department to internally operate the lockbox system for voluntary accounts currently serviced by the State Street Bank. The lockbox is designed to distribute weekly obligation notices and accept collection payments. It does not, however, notify an absent parent if the account becomes delinquent. The Department is working to ensure that its management information system, Model II, will have the capability to implement a centralized collection process in FY87.

o Court Initiatives

The primary barrier in obtaining child support collections is the CSEU's dependence on the court system for the establishment, enforcement and collection of support orders. Nearly 60% of AFDC cases referred to the CSEU become court cases. These cases include contested paternity cases and other legally complex child support cases. These cases become part of the lengthy backlog of child support cases in the court system.

During FY86, CSEU managers have met regularly with the presiding justices of various district courts to discuss the child support program, the Westboro/DoR project, and performance-based contracts designed to assist the court in their collections.

o Performance-Based Contracts

The CSEU developed an open proposal project in FY86 designed to improve collection performance. Proposals have been invited by the Department and are being evaluated on the basis of the potential impact on total dollars collected.

Eligible applicants for these funds include individual courts or collaboratives of two or more courts, the state police, district attorneys' offices, and other state agencies.

This project provides bidders an opportunity to meet and surpass Department determined collection goals in exchange for funds to acquire the necessary resources to do so. Resource requirements vary from bidder to bidder. For example, while one court may need to hire a probation officer who will be responsible for child support collection activities, another bidder may need clerical assistance to process collection payments.

It has been anticipated this project will inspire innovative project ideas for field operations which can be expanded in FY87.

FUTURE DIRECTIONS

A. Federal Policy Changes

According to the federal Office of Child Support Enforcement, in 1981, although most of the 8.4 million single headed families in the nation should have been receiving child support payments, obligations had been established on behalf of only four million. Of the four million who had child support orders issued by the judicial system, 53% received only partial payment or no payment at all. Four billion dollars a year is not being collected for children to whom it is rightfully and legally due.

Alarmed at the parental evasion of child support responsibilities and its resultant adverse social and economic effects, Congress passed the Child Support Enforcement Amendments of 1984 (Public Law 98-378) to encourage states to pursue and collect support payments more aggressively. The new law has four major themes:

- o child support services must be provided to all families that need them, including both AFDC and non-AFDC families.
- o states must use enforcement techniques that work
- o federal financing and program audits will be used to stimulate and reward improved program performance
- o interstate enforcement must be emphasized and improved.

The amendments require states to implement the following enforcement techniques:

- o automatic, mandatory wage withholding when support payments are delinquent. If an absent parent falls behind in child support payments, the amount of the support order would automatically be deducted from the absent parent's paycheck in a system similar to state and federal tax withholding.
- o expedited procedures for establishing and enforcing child support obligations so that support cases no longer contribute to already crowded court dockets.
- o state tax refund intercepts for non-AFDC cases.
- o liens on property in district court.
- o a single wage withholding agency responsible for collecting and discharging child support payments on behalf of both AFDC and non-AFDC families.

- o reporting to consumer credit agencies, upon request, if an absent parent is delinquent on child support payments by \$1,000 or more.
- o a Child Support Commission in each state to examine its child support enforcement system and to recommend improvements in that system which would meet the federal requirements listed above. These requirements must be met by all states as a condition of continued receipt of federal funding under Title IV-D of the Social Security Act. States who do not comply risk penalties ranging from 1 to 2% of federal AFDC reimbursement to loss of all federal reimbursement on AFDC and Title IV-D expenditures.

B. Massachusetts Child Support Commission

The Governor's Child Support Commission was appointed in December, 1984 and has 32 members who represent advocacy groups, courts, district attorneys, and human service agencies interested in child support enforcement as well as the Welfare and Probation Departments which are involved in the enforcement process. Catherine M. Dunham, Director of the Governor's Office of Human Resources, was appointed chairperson.

The Commission adopted recommendations from five subcommittees (enforcement, expedited procedures, guidelines, services to non-AFDC clients, and legislation) and submitted its findings and recommendations to the Governor, the Secretary of Health and Human Services and the public in mid-October. These recommendations impacted both AFDC and non-AFDC cases and centered on the following three key areas.

o Tougher Enforcement of Child Support Orders

In order to ensure fairer and more effective enforcement of support orders to children, the Commission recommended:

- Automatic income assignments: in all cases except when both parties agree to a voluntary arrangement or a judge makes an exception in writing.
- Federal and State income tax refund intercepts of persons owing past due child support.
- Notification to credit agencies, upon request, when absent parents owe \$1,000 or more in past due child support.

o Fairer, More Uniform Child Support Orders

The current child support system has been criticized as discouraging payment of support orders because of the lack of consistency in award amounts from court to court. At present, there is no consistent methodology for the establishment of child

support orders. Absent parents with identical wage earnings, payment history, number of children and similar living situations are often awarded very different orders in different courts and at times in the same court.

To encourage compliance, the Commission recommended the adoption of guidelines in the form of a simple (percentage) formula for use by the courts in deciding the amount of child support. The Commission recommended that these guidelines be developed by a committee chaired by the Chief Administrative Justice of the Trial Court. Guiding principles would include fairness, uniformity, predictability and adequate levels of support.

o More Efficient and Responsive Child Support System

The current child support system is inefficient, slow, complicated, and hard to navigate. The administration of child support varies widely among the 69 district courts, 13 probate courts, 11 district attorney offices and 50 local welfare offices. The involvement of all these entities creates a fragmented, complex system accountable to no single authority. The Commission recommended:

- Court Masters to deal exclusively with child support cases in both probate and district courts. Masters would be full-time employees of the judicial department and be selected by an eleven-person committee, appointed by the Governor. The masters will be assigned to various courts by the chief administrative justices of the court departments.
- Strong Child Support (Title IV-D) Agency to centralize the collection of support payments, services and enforcement; provide equal services to AFDC and non-AFDC families; and be sensitive to all consumers including children, custodial and non-custodial parents.

The Commission did not identify or recommend which agency should be designated as the IVD agency; and

- Civil Process to establish support orders and determine paternity in a civil proceeding in both the probate and district court departments, preserving criminal non-support action for flagrant delinquencies in the district court. Paternity proceedings would become civil proceedings to allow for faster processing and a civil standard of proof. Blood and genetic test results and statistical probability of paternity should be allowed as evidentiary elements in these proceedings.

C. Pending State Legislation

In order to implement the Commission's recommendations and be in compliance with the 1984 federal amendments, in 1985, the

administration filed an Act to Improve the Collection of Child Support. The bill contains the following major provisions.

- o A Strong IV-D Agency is recommended and the Welfare Department is designated. The Department is required to establish an efficient, computerized collection and disbursement system for all child support checks, including support checks on behalf of non-AFDC recipients to custodial parents.
- o Expedited Process and a System of 40 to 50 Child Support Masters in the 84 probate and family courts, the Boston Municipal Court, and the district courts, with a supportive number of clerical positions. Child support masters would hear all support matters.
- o Automatic Wage Assignment unless the court finds in writing that one is not needed. The only alternative to the immediate wage assignment is a 14 day suspended assignment that is not implemented as long as the payor does not go two weeks or more into arrears.
- o Civil Paternity Adjudication which could be brought in the district, probate and family, or the Boston Municipal courts. (Currently all matters are heard in the district court department in very complex criminal proceedings which result in significant time delays of up to six months or longer.) Child support masters would not be allowed to decide paternity issues. Assistance to complainants, including representation in AFDC cases, would be provided by the IV-D agency. Modern, scientific blood tests would be admissible.
- o Support Order Guidelines to be developed by the Child Support Masters Committee and filed with both branches of the General Court ninety days before they become effective. Automatic increases and decreases in orders as wages change and interest on arrearages in flagrant non-support cases at the discretion of the master are two issues to be addressed.

D. Further Steps

While the Department endorses both the recommendations of the Commission and the proposed legislation which would implement its recommendations, there remain opportunities for greater improvement which should also receive consideration.

- o Apply automatic income assignment to existing cases, not just new cases and modifications.
- o Ensure support and income guidelines are established and utilized at the time the income assignment provision becomes effective.
- o Assist families in poverty to move off the caseload into self-sufficiency by providing a child support payment bonus for participation in the ET Choices program.

E. Implementation Issues

The Child Support Commission, pending legislation and the Department all agree on the need for major revisions in the operation of child support enforcement. Proposed revisions raise issues which will influence the effectiveness of the changes, including:

- o for child support masters, once selected, training and education in child support procedures and issues.
- o education of employers in the Commonwealth about automatic income assignment.
- o administrative and computer system capacity utilizing a single data base to handle the volume of cases and disbursement of checks which will be required in all cases for all employers and existing orders in the state.
- o a wage guideline committee needs to be established, so that recommendations can be developed for legislative enactment.

F. Potential Federal Sanctions

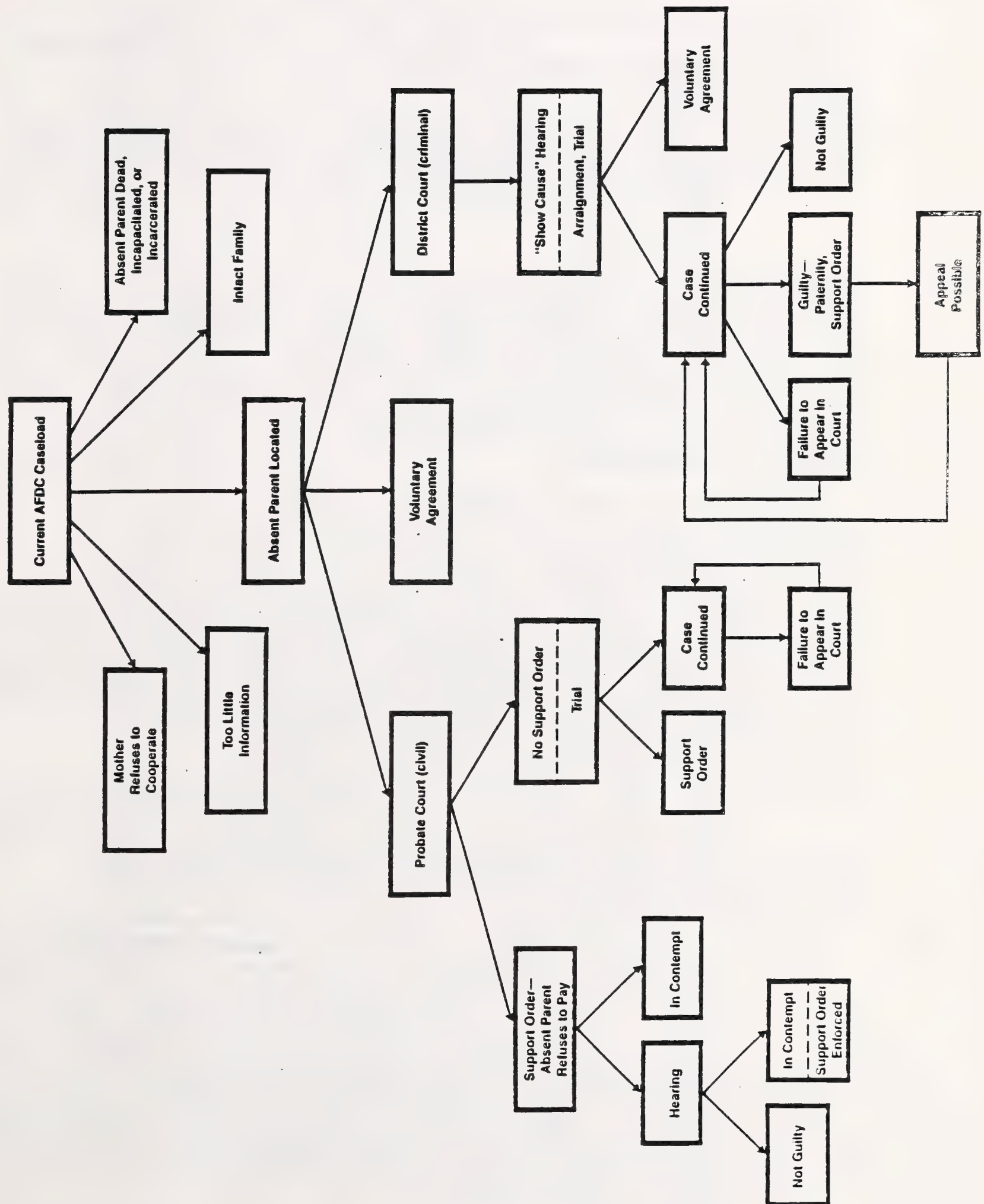
The risks for states who do not comply with the requirements of the federal amendments range from penalties of one to two percent of federal reimbursement on AFDC expenditures to loss of all federal reimbursement on both AFDC expenditures and IV-D expenditures. The Department believes passage of child support legislation early in the 1986 legislative session will enable it to avoid any federal penalties.

OVERVIEW OF CURRENT CSEU PROCESS

A. AFDC Services

Local welfare office staff refer all AFDC applicants who may be eligible for child support to the CSEU. The CSEU uses its local, state and federal resources to locate or properly identify absent parents who cannot be identified by the custodial parent. Once the identification is made, unless there is an outstanding court order for child support, the CSEU offers the absent parent an opportunity to establish a voluntary agreement with the CSEU to make regular child support payments. If the absent parent denies paternity or does not make payments voluntarily, the CSEU refers the case to court. The state judicial system is responsible for establishing and enforcing child support orders. The CSEU enforces voluntary obligations through delinquency notices and court actions. The CSEU relies on the courts for the use of such enforcement techniques as wage assignments, liens against property, federal and state tax intercepts and incarceration. Staff in the Department's central office and in 50 of its larger local offices administer the Department's child support program.

CHILD SUPPORT ENFORCEMENT SYSTEM



In the Department's local offices child support staff:

- o interview the AFDC recipient and attempt to locate the absent parent;
- o interview the absent parent after he has been located, to establish a voluntary agreement or refer the case for a court order. The worker prepares the case to have an order established, and once an obligation has been established, either voluntarily or through the courts, monitors the payment record.
- o Department legal staff represent the CSEU as needed in court actions to establish, enforce and modify orders. Primarily, the Department's attorneys represent the agency in actions to increase existing support orders or to establish orders in pending actions for divorce. The Department's attorneys also obtain liens and attachments against absent parent property which can be liquidated to satisfy delinquent support obligations.

Each of these three components is described briefly below and is illustrated by the accompanying flow chart.

o Location of Absent Parents

In over two-thirds of the cases that reach the local child support office, the CSEU must locate or verify the location of the absent parent. Nearly 50% of the CSEU cases involve parents who were never married. In many instances, the relationship between the parents was brief and may have terminated years ago. Thus, the client is not able to provide the information regarding the absent parent or his current location.

Local office CSEU staff are encouraged to do as much of the initial location effort as possible through standardized location techniques such as postal verifications, local telephone directories, information and materials supplied by the CSEU client, licensing boards, and public assistance records.

If the local office is unable to locate the absent parent, the local office refers the case to the Central Parent Locator Unit (CPLU) in the Department's central office. The CPLU handles an average of 1700 to 1800 new requests for information per month (or approximately half of new CSEU cases per month). The CPLU has access to information from other state agencies such as the Registry of Motor Vehicles, the Department of Probation and the Division of Employment Security in order to obtain social security numbers, criminal record information and financial histories. With the absent parent's name and social security number, the CPLU can request the Federal Parent Locator Service (FPLS) to check records with various federal agencies for current address and other information.

The key to location efforts is the absent parent's social security number. The absent parent's social security number is required before the CSEU can request a current address from federal tax officials. It can take up to four months to get a social security number. Since tax records are generally one year old, the CSEU is still not guaranteed of obtaining a current address even at the end of this process and takes up to three months to receive response to requests. Given the current difficulties in obtaining information, approximately 40% of the absent parents who are sought are never located.

o Establishment of Obligations

Approximately 60% of the cases that the AFDC worker refers to the local CSEU workers do not have existing court-established child support orders. Once the parent has been located, the CSEU seeks to establish an agreement with the absent parent to support his family -either a voluntary agreement made in the local office or, if necessary, an order by the probate or district court. Generally, if the parents were married at the time the child was born and have since been divorced, the case can be referred to one of the 13 probate courts for the enforcement of an existing support order.

If the parents were never married, or if one parent left the home without any divorce proceeding, the CSEU can pursue one of two courses. If the absent parent agrees to sign a voluntary support agreement and subsequently makes payments regularly, the agreement can be monitored by the CSEU. Therefore, if the absent parent fails to make regular payments, or if the individual claims that he is not the child's parent and paternity has to be adjudicated, then a child support enforcement worker has to take the case to one of the Commonwealth's 69 district courts. A support order that is established by a district court judge can be monitored either by the district court probation department or by one of the local CSEU offices in conjunction with the probation department.

The total number of open AFDC cases with established obligations is 31,400 or 40% of the potential CSEU caseload. In addition to location difficulties, two major obstacles prevent the establishment of child support obligations for the other 60% of the AFDC cases:

- paternity disputes; and
- delays in the judicial system.
- Paternity disputes arise when the absent parent refuses to acknowledge paternity. The CSEU must then take the case to a district court to prove paternity. Only after paternity has been adjudicated can the district court order the parent to pay support and accept financial responsibility

for his child. At present, proving paternity through the courts in Massachusetts is quite difficult. Existing state law makes blood test admissible in courts only to exclude the paternity of the absent parent, but not admissible to prove paternity. This state law is maintained even though certain types of blood tests have been found by the Department of Health and Human Services to have a 98% accuracy rate. Proposed state legislation would admit specific blood tests as evidence to establish paternity.

Moreover, the percentage of AFDC cases that involve children whose parents were never married has grown from 22.7% in 1975 to 49.1% in October 1985. This increase in the number of AFDC children born out of wedlock has increased the difficulty of the CSEU because once the absent parent has been located, the CSEU must then establish paternity before a support order can be established.

- Delays in the judicial system also provide an obstacle to establishing obligations. Especially in district courts, child support cases must compete with other serious criminal cases for limited court resources. Establishing a court-ordered obligation is a lengthy process. The child support portion of the court caseload includes new CSEU referrals, as well as cases to enforce the payment of arrearages. Court dates are scheduled as far as two months in advance. If the individual does not appear in court or is not prepared, one or more continuances are routinely granted, further lengthening the process. With each successive continuance, the chances of the case's completion diminish. As many absent parents move without leaving a forwarding address, the CSEU must relocate the parent. Failure to appear at court, or defaulting, is also a deep-rooted problem in the Massachusetts criminal justice system. Preliminary analysis suggests that child support cases in default range from 20% in some district courts to as high as 60% in others. Child support cases can take anywhere from three weeks to six months to be completed. It is not uncommon for paternity cases to take up to six months or more for an order to be established.

o Enforcement of Obligations

The Department does not receive payment from approximately 50,000 (64%) of over 76,00 established obligations. In the 36% of cases where payment is made, the payment is only a fraction of the monthly amount that is due. Voluntary cases have the best overall compliance rate in the number of cases which make payments, although the established obligation amount (amount of support absent parent is required to pay) is the lowest. The CSEU receives the largest percentage of its collections from probate court obligations. The Department uses several key strategies for enforcing existing obligations, described below.

- The CSEU initiates notices to delinquent cases, including telephone contacts, mailed delinquency notices, and a court referral if the case continues to default on payments. Collecting delinquent payments is time consuming. To increase collection from delinquent cases, the CSEU has established a pilot project using the services of private collection agencies.
- The CSEU has established a blanket contract for collection agency services to secure collections from absent parents who are overdue in their child support payments.

In FY86, the CSEU has submitted a number of voluntary agreement cases which are in arrears to several collection agencies for a concentrated collection effort. Since April 1, 1985, the collection agencies have recovered \$130,000.

- State and federal tax refund intercepts where the arrearage totals \$150 or more and is at least three months delinquent.

B. Non-AFDC Services

Pursuant to the requirements of federal legislation, the Department began providing additional services to non-AFDC clients on October 1, 1985. These services include:

- o information packets on the Commonwealth's child support system;
- o the submission of names to the Internal Revenue Services for tax intercepts;
- o absent parent location services using the same resources as is utilized for AFDC recipients;
- o payment for the cost of warrants served by the probate courts on behalf of non-AFDC clients. (A warrant may be issued for an absent parent who has defaulted on his child support payments in an attempt to bring the absent parent back into court to enforce support payments.)

FY87 REQUEST

Although the CSEU's accomplishments have been significant and the Department expects continued progress and success, an aggressive and concentrated effort will be required to achieve the 12.6% increase above the FY86 goal to \$56.3 million in collections in FY87.

The Department requests \$10.3 million to provide child support services in FY87. The request is outlined below.

Child Support Enforcement (4400-1004)

1. Personnel (01,02)	\$6,825,023
2. Travel	67,000
3. Performance-Based Contracts	605,044
4. Westboro DoR	30,815
5. Court Default Project	193,369
6. Clearinghouse Project	800,000
7. Automated Billing System	300,000

Subtotal FY87 Request \$8,821,251

Child Support Systems (4400-1014)

8. Model II Maintenance & Development	\$980,000
o Lockbox.	
9. Court Cooperative Agreements	300,000
10. Location and Collection Fees	177,000
o IRS Intercept	\$ 64,000
o IRS Full Collection	110,250
o Project 419	2,750
(federal parent location service)	

Subtotal FY87 Request \$1,457,000

Total FY87 Request \$10,278,251

This request will fund several key initiatives, including:

- o performance-based contracts;
- o an automated centralized collections system; and
- o Model II management information system enhancements.

A. Performance-Based Contracts

The CSEU believes a primary barrier in obtaining child support collections is the CSEU's dependence on the court system for the establishment, enforcement and collection of support orders. In FY87, the CSEU believes performance-based contracts will provide a more cost-effective method for achieving child support collections. These contracts would allow the courts to assume responsibility for the majority of child support collections. However, a major provision of the contracts would require that the courts achieve established collection goals in exchange for additional resources. Wage assignment would provide a vital means of achieving these goals and ensuring support cases make regular payments. Wage assignment would also help alleviate some of the burden on the court system in continually reprocessing default cases.

B. Automated Centralized Collections

A major proposal by the Department for FY87 is to redeploy field staff from each of its local support units to the courts to perform functions which have a more direct impact on collections, such as the establishment and enforcement of support orders. By centralizing and fully automating the collections process, the Department would make resources available to achieve this goal.

Presently, child support is collected by 69 district courts, 12 probate courts, 50 local welfare offices and by the State Street Bank under contract with the Department of Public Welfare. Two major computer systems and a number of smaller systems perform an accounting function for child support payments.

This collection process is difficult to manage. In FY86, the Department is working toward an automated system of collections using both the resources within the Department (Model II) and the private sector (State Street Bank lockbox program and collection agencies) which will strengthen Department-controlled collections. This initiative would expand in FY87 to include all collection activity, including the courts. As this system becomes refined, CSEU field personnel would be freed from their current duties receiving checks, posting the payments and batching checks, and be freed for more productive tasks.

C. Model II

In order to reach its goal of a centralized collection process, the CSEU must implement the following two projects:

- o The Clearinghouse Project, designed by the federal government to enable every state child support enforcement program to establish a centralized registry of CSEU clients and absent parents. Through this project, the CSEU would strengthen its information-gathering capability with other agencies. The goal of this project is a communication system between the court's Probate Receipt Accounting (PRA) system and Model II. This project is 90% federally reimbursed.

Developing the capability to interface with the automated court PRA system will be an immediate priority in FY87. This would aid the CSEU efforts in improving the court child support collections. For instance, this initiative would enable the CSEU to match every CSEU name, address, and social security number with existing information in court files.

The ability to interface with the court PRA system is an essential component of the performance-based contracts and efficient use of staff. At present, the court PRA system maintains the most accurate, up-to-date information of all court-ordered child support obligations. For the CSEU to be most effective in monitoring the courts' collection goals, as

well as tracking their own court-ordered cases, communication between the PRA and Model II system is a vital necessity.

- o Development of an automatic billing system for child support cases similiar to the system used by the Department's Finance Division to recoup overpayments from recipients. Computerized files maintain records of the cases' total balance due, monthly repayment amount, and the most recent payment. On a monthly basis, a computer tape indicates the payment status of each case. Based on this information, one of eight different dunning notices is sent to the recipient informing him or her of the gravity of his or her delinquency. The CSEU would expand this current system to address the large delinquency problem in absent parent cases in FY87. This program initiative also supports implementation of a centralized collection process.

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CHILD SUPPORT BASIC FACTS FY86

- o FY86 Collections Goal \$50 million
- o YTD FY86 Collections (Dec. 1985) \$23.73 million
- o Total FY85 Collections \$45.1 million
- o Projected FY86 AFDC Caseload 85,356

ESTABLISHED OBLIGATIONS
(Through October 31, 1985)

	Open AFDC Cases			Closed AFDC Cases			Total		
	Obligations	Cases that Pay	Compliance %	Obligations	Cases that Pay	Compliance %	Obligations	Cases that Pay	Compliance %
Voluntary	10,192	5,347	52.5	7,941	2,746	34.6	18,133	8,093	44.6
Probate	8,248	4,632	56.0	17,942	4,277	23.8	26,190	8,909	34.0
District	12,960	5,998	46.3	19,127	4,420	23.1	32,087	10,418	32.5
	31,400	15,977		45,010	11,443		76,410	27,420	
Open AFDC Compliance Rate: 50.9%			Closed AFDC Compliance Rate: 25.4%			Overall Compliance Rate: 35.9%			

Average Established Obligation Amounts

Voluntary Orders	\$121.63
Probate Orders	\$196.90
District Orders	\$139.50

MEDICAID MANAGEMENT (4400-1003)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditure/ Appropriation	\$16,866,592	\$4,313,812	\$5,000,000	\$18,435,658

The Medicaid Management account funds most personnel and support expenses associated with managing the Medical Assistance program (Medicaid) and the Medicaid savings agenda.

During FY83 and FY84, this account funded all costs associated with the Medicaid Management Information System (MMIS) and several units within Medicaid responsible for savings and program management. Prior to the enactment of the FY85 budget, the legislature reorganized all administrative account funding. While Utilization Review was merged with this account, other functions previously funded here were transferred to the Contract Operations and Management and Support accounts. The funding levels for FY85 and FY86 reflect this transfer. In FY87, the Department proposes consolidating all Medicaid management and savings activities into a single account.

In FY87, the activities proposed through the Medicaid Management account focus on four Department priorities:

- o Savings - Personnel funded out of this account are responsible for the \$262 million agenda of new and continuing Medicaid savings initiatives. The FY87 Medicaid budget of \$1.23 billion, representing about 15% of the total state budget, would be 21% higher or \$1.49 billion without the savings and revenue agenda.

The FY87 increment to the Medicaid savings agenda totals \$42 million over and above the continuing savings of \$220 million generated in past fiscal years. The Department is requesting funding in this account both to cover ongoing activities which maintain the base savings of \$220 million and to provide resources which will allow the Department to realize \$42 million in incremental savings.

- o Access and Provider Services - The Department is responsible for making sure that its elderly, disabled, and low-income clients can get the health care services they need. Activities in this area include a client access hotline, a client service office at Boston City Hospital (which provides care to more Medicaid clients than any other provider), and staff to manage programs to meet the health care needs of the disabled and other specific populations. A less well-recognized, but not less important aspect of the agency's efforts in this area, is efficient management of the program's infrastructure. If providers cannot get legitimate bills paid promptly and cannot get quick responses to questions about whether a service is covered, or find

Medicaid-related paperwork confusing and burdensome, they can choose not to participate in the program. Physicians, dentists, and other office-based providers, for whom Medicaid may often be only a small portion of their practice, are particularly likely to respond negatively to a poorly managed Medicaid program. Keeping these and other providers in the program is essential to the goal of enabling clients to obtain the care they need in nearby and cost-effective settings. This account funds a number of the activities which make the program's operations run smoothly. These activities include maintaining provider enrollment files, updating regulations and billing instructions, reviewing provider applications and working with provider associations and individual providers to resolve issues which providers see as reasons not to participate in the Medicaid program.

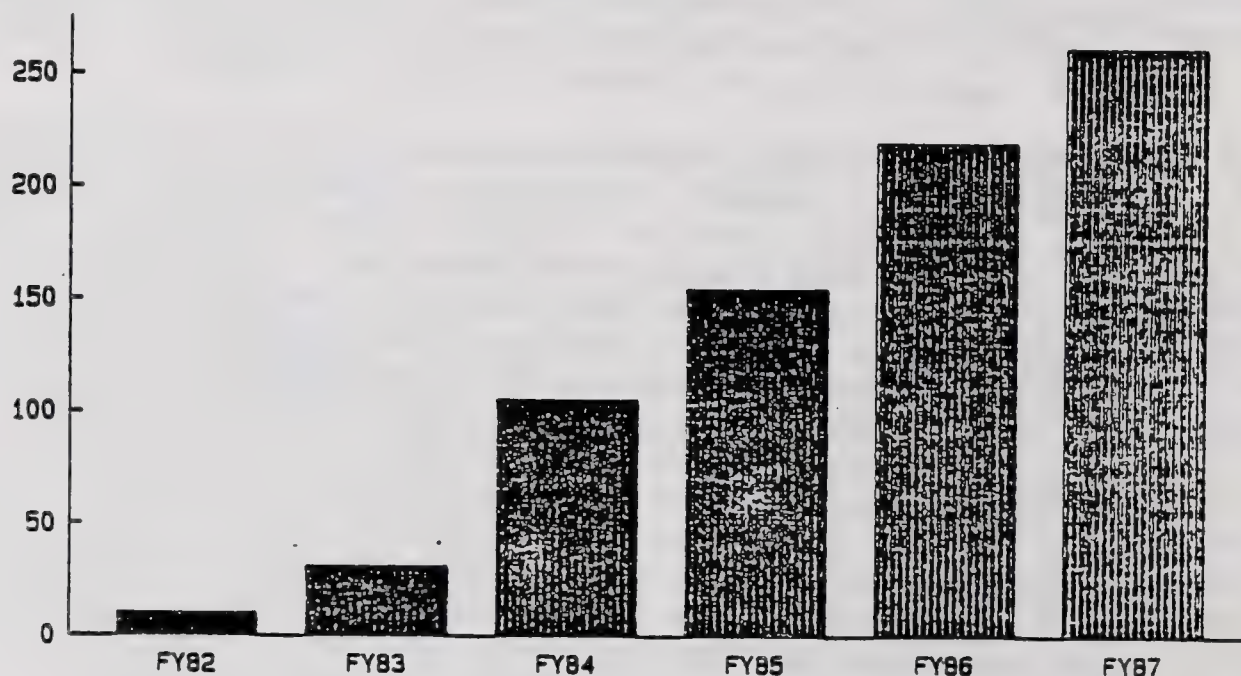
- o Health Choices - The Department believes that a restructuring of the Medicaid program is necessary in order to ensure that recipients are able to secure high-quality health care at a reasonable cost to the state. Health Choices represents an innovative effort to restructure the current fee-for-service system through a three-pronged system designed to offer comprehensive and high quality care to Medicaid families. This account will fund the initial phase of this approach, which the special report on Health Choices describes in detail.
- o Long Term Care - Long term care costs absorb 50% of the entire Medicaid budget. Indeed, the Medicaid program pays for about 70% of the state's more than 50,000 nursing home and chronic hospital beds. Further, the proportion of the state's population which is elderly is growing, and the state's Medicaid statutes and regulations mean that the program is responsible for serving a higher than average proportion of those elderly. This account funds staff responsible on a day-to-day basis for arranging an appropriate level of support for elderly clients in need of long term care so that clients who do not need institutional care can remain in the community. This account also funds staff and related costs associated with the Department's effort to develop more cost effective ways of serving the elderly in the future. These activities and the Department's role in long term care are described in more detail in the Medicaid narrative's discussion of caring for the elderly.

MEDICAID SAVINGS AGENDA

As noted above, the magnitude of the Medicaid budget, over 15% of the total state budget, requires that the Department pursue savings initiatives in order to control spending growth. In response to these fiscal realities, the Department has developed and implemented an annual Medicaid savings agenda. Most staff responsible for executing the savings agenda are funded out of this account. The following chart illustrates the success of savings initiatives since FY82.

MEDICAID SAVINGS FY82-FY87

millions of dollars



Continued funding for administrative and managerial resources is needed to maintain ongoing initiatives which form the savings base and to expand the savings agenda. Without sufficient staffing in various units responsible for savings and revenue, the Department would not only be unable to reach its FY87 target of \$42.25 million in new savings, but would also have difficulty maintaining base savings reductions of \$220 million.

A. Third-Party Liability

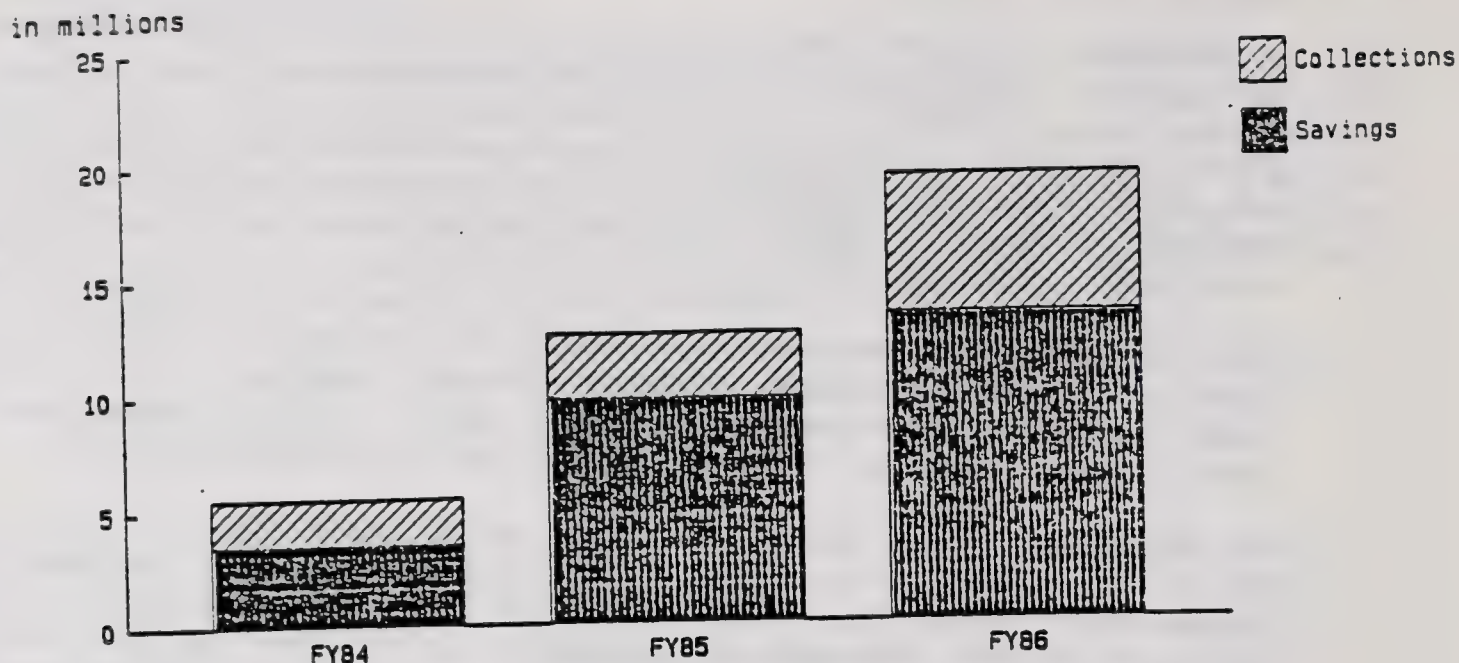
As defined by federal regulation, a third party is any individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for a recipient of Medicaid. Both federal and state Medicaid regulations require providers to bill all other available sources of payment for recipients' care before billing the Department. Medicaid is the payer of last resort.

Many Massachusetts Medicaid recipients, an estimated 34%, have some form of health insurance coverage through Medicare, Medex, Blue Cross, or other insurers. However, there is no single way to identify which clients have coverage or what coverage they have.

The Department, with support from the legislature, has established a Third Party Liability Unit (TPLU) to maintain and expand TPL information. Staff has full responsibility for the identification, verification and storage of insurance information for the entire Medicaid population. TPLU generates savings for the Department in two ways.

- o Collections - The TPL unit actively seeks to collect refunds from providers and other insurers for claims the Department has already paid but for which other insurers were legally responsible. The Department sometimes becomes aware of the existence of third-party coverage only after Medicaid has already paid for the services. For example, certain providers, especially nursing homes and chronic hospitals, are heavily dependent on Medicaid revenue. These providers generally bill Medicaid and other insurers simultaneously in order to ensure themselves an adequate cash flow. In fact, Medicaid should be billed only after all other insurers have been billed. Providers are required to return to the Department any payments received for services paid for by other insurers and also by Medicaid. However, these providers do not always make these refunds, nor, since they can count on Medicaid, do they always bill other insurers. By addressing this situation, the Department projects cash collections in this area will reach \$6.0 million in FY86, 140% higher than the FY85 collections of \$2.5 million.
- o Savings - Savings can be generated by identifying recipients with third party coverage prior to delivery of health care services. National studies document that, on average, private health insurance benefit plans cover the annual value of \$630 worth of medical services for each Medicaid recipient covered. Thus, the Department's Third-Party Liability (TPL) program's primary objective is to develop and implement measures to identify recipient third-party insurance resources and to apply these resources towards the cost of recipient's medical services.

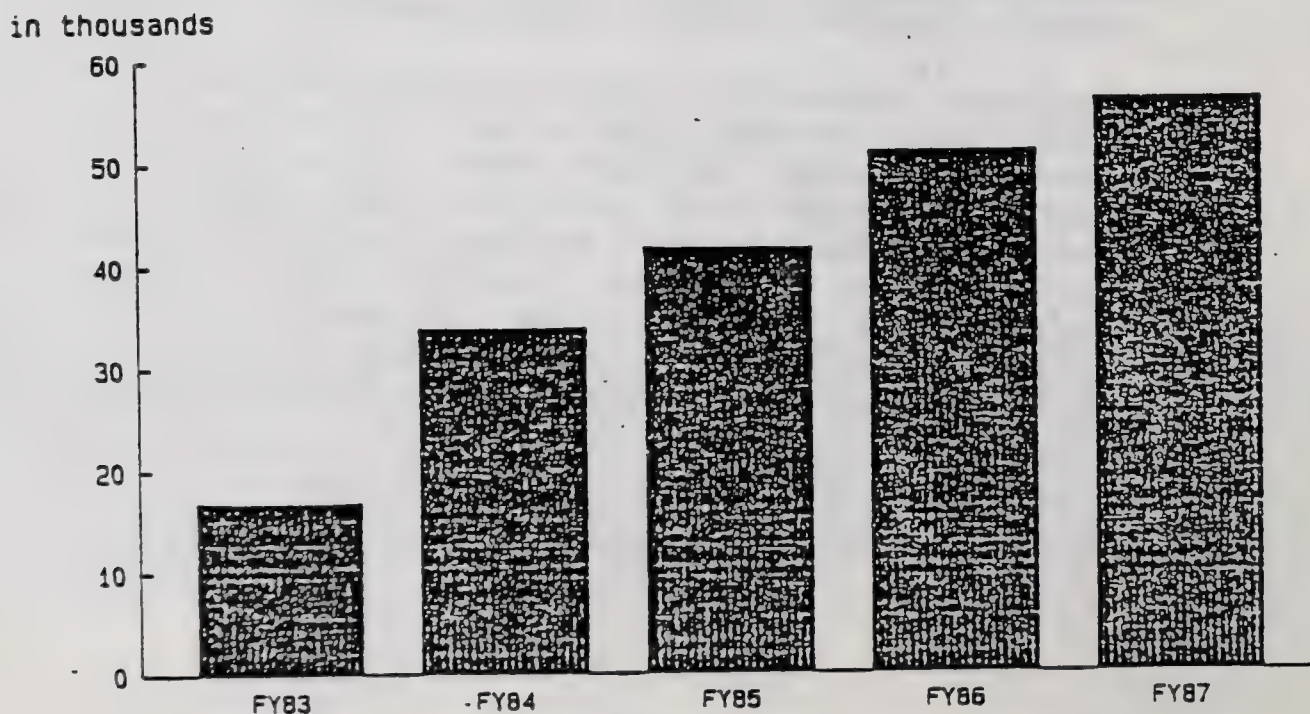
THIRD PARTY LIABILITY SAVINGS AND COLLECTIONS



In FY87, the Department anticipates savings and collections to total \$13.65 million. The goal of TPL has been to identify all Medicaid recipients with other types of health insurance. TPL has been quite successful thus far, identifying increasing numbers of the Medicaid population with TPL coverage over the last few years. It is likely that this rate of growth will begin to slow in FY87 and subsequent years as the available pool of TPL-eligibles on Medicaid but not yet identified as possessing health insurance declines.

By the end of FY87 the Department will increase recipient identifications of third party coverage to 56,000, which represents a 60% increase over identifications through FY84.

THIRD PARTY LIABILITY NUMBER OF RECIPIENTS IDENTIFIED WITH THIRD PARTY COVERAGE



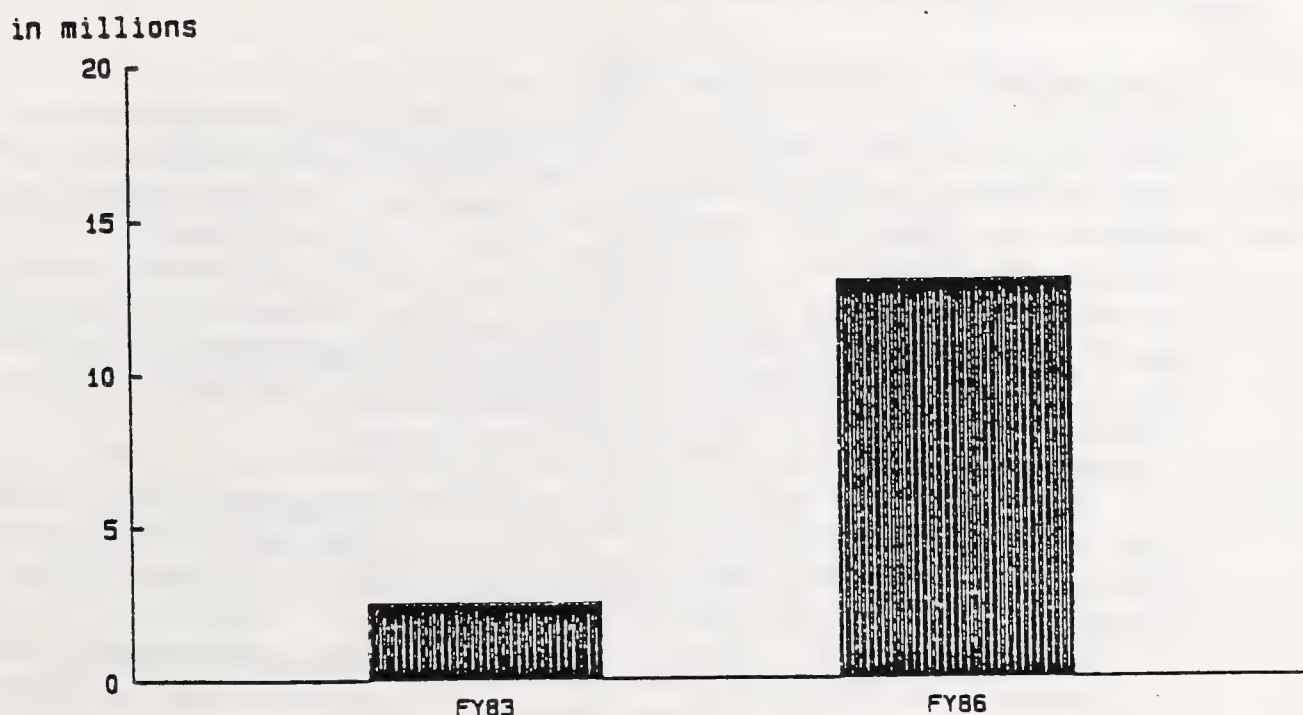
Because the Department has successfully increased the number of recipients identified as having third party coverage, savings attributable to this effort have also increased. Between FY84 and FY86, the Third Party Liability Unit has been responsible for \$30.9 million in savings. In FY87, if the resources proposed in this account are approved, TPL will achieve an additional \$13.65 million in savings and revenue through maximizing Medicare and private health insurer contributions to the cost of care for Medicaid recipients, Medicare Part B repricing, and expanded identification of veterans' benefits.

B. Provider Review

Provider billing errors, abuse, fraud, and inappropriate medical practices are recurrent problems for the state's Medicaid program and for Medicaid and other health insurance programs nationally. The Department, through its Provider Review and Sanctions Unit (PRSU), seeks to control these provider problems through audits of provider financial and clinical records.

In FY86 and FY87, the Department plans several improvements to its existing provider review operations. These include increasing the number of audits substantially over FY85 levels (by 500%) and modernizing audit protocols for several provider types. These initiatives and continuing program operations will result in significant recoveries. Recoveries total \$13 million in FY86; another \$8 million is proposed in FY87, bringing the cumulative total from FY83 through FY87 to approximately \$37 million.

RECOVERIES FROM MEDICAID PROVIDERS FOR FRAUD, ABUSE, AND ERRORS FY83 v FY86



C. Medicaid Cost and Quality Control Unit (MCQCU)

The MCQCU is responsible for:

- o coordinating Medicaid efforts to implement and successfully execute the savings agenda;
- o identifying slippage of or obstacles to savings, and developing corrective action plans, where necessary;
- o analyzing utilization and expenditure data generated by MMIS and the proposed provider practice pattern analysis system (described later in this narrative) and implementing strategies to eliminate inefficiencies identified through this information.

D. Utilization Control

Another important factor affecting the level of Medicaid spending is utilization of resources; that is, the amount and intensity of health care resources used by each recipient. Each month recipients are issued Medicaid cards, which provide them with virtually unlimited access to the state's extraordinary health care system. Recipients may obtain almost any service in almost any health care facility in Massachusetts. Providers then bill the Department for each service obtained. Thus, the Department pays for recipient and provider decisions about the use of services, but has little influence over those decisions. By developing initiatives that influence recipient and provider practice patterns, the Department can increase its control over the quality of care that recipients receive. In FY87, the Department proposes two new utilization control initiatives aimed at reducing Medicaid costs, while also providing recipients access to appropriate quality care. These initiatives are a pre-admission screening program and a provider practice patterns analysis system.

o Pre-Admission Screening Program

Most of the Department's utilization control initiatives, with the exception of the nursing home pre-screening program, monitor activities after the service is provided. Retrospective reviews, although they may have some indirect influence on future behavior, are not the most effective method of controlling utilization. Control of Medicaid costs and improvements in quality of care depend on a prospective approach which seeks to prevent inappropriate health care utilization, rather than retrospectively reviewing treatment patterns.

In FY87 the Department intends to implement a pre-admission screening program, initially on a selective basis, for acute care hospitals to correct inappropriate utilization practices.

A prospective pre-admission screening program is needed not only to control acute inpatient hospital expenditures but also as a means of ensuring quality care to Medicaid recipients. The

current fee-for-service system at least implicitly encourages providers to deliver more intensive services than necessary as a means of increasing their reimbursement. Recipients have little protection from this practice and may be receiving health care services that are not medically necessary.

Studies have indicated that pre-admission screening programs do in fact reduce the number of inappropriate inpatient hospital admissions. Often, admissions are diverted to more appropriate treatment settings. Reducing inappropriate admissions also protects recipients from contracting iatrogenic illnesses, illnesses which occur as a result of hospitalization.

In September 1983 the Kentucky Peer Review Organization (KPRO) implemented an acute inpatient hospital pre-admission screening program in Kentucky for both Medicaid and Medicare recipients. During its first year of operation, Medicaid and Medicare admissions dropped 10.6% and 6% respectively. KPRO has experienced few denials of admissions and believes the decrease in admissions is due to a "sentinel" effect: pre-admission screening programs require physicians to justify every hospitalization, meaning that physicians weigh marginal cases more carefully. Initial assessments of the program indicate substantial savings potential. Michigan, California, and Minnesota are among several other states which have also instituted comparable programs. Additionally, Blue Cross (through Master Health Plus) and other private insurers have added preadmission screening protocols to their insurance plans.

The Chrysler Corporation also instituted a pre-admission screening program in 1984 for its employees. After one year of program operation, Chrysler has issued a report stating that the program has saved a total of \$32 million, of which \$22.0 million is attributable to doctors fees and tests largely associated with hospitalization.

The Department plans to implement a limited pre-admission screening program for acute inpatient hospital admissions. The program is still under development and will likely be initially targeted to a specific group of hospitals for specific categories of admissions. The selected admissions will be reviewed for appropriateness of the admission or procedure, based upon a set of pre-established and generally accepted evaluation criteria. The program will include careful safeguards to ensure that clients are not diverted from receiving necessary care.

The pre-admission screening program offers tangible benefits to recipients and the Department. For the first time the Department will be able to make a prospective determination of the appropriateness and medical necessity of a procedure. In addition, this program will serve as a safeguard for the right of recipients to receive quality care in the most appropriate health

care setting. Clients will not have to be admitted as inpatients for services they could obtain as outpatients.

The Department anticipates that this program will realize savings of \$2.5 million in FY87.

E. Provider Practice Patterns Analysis

The present utilization system is retrospectively oriented, that is, it measures appropriateness and necessity of a service after it has been provided. In order to control utilization prospectively, the provider community must be educated on the possibilities of alternative treatment patterns as practiced by their peers.

To date, the small-area comparative analyses have examined user rates of selected hospital services for the general population. The results show that variances in treatment patterns are frequent. These variances may be justified, but they may also indicate excessive and inappropriate utilization of services. Providing unnecessary services, particularly unwarranted surgical care, is both costly and potentially dangerous as it unnecessarily places individuals at risk of preventable complications and of iatrogenic diseases contracted in the hospital during recuperation.

The Provider Practice Pattern Analysis project addresses these issues by incorporating data from MMIS/SURS and data from other data bases into one complete information set.

Developing a new data base which incorporates but is not limited to MMIS to analyze provider practice patterns is required. The current subsystem within MMIS responsible for utilization review is designed to identify aberrant and potentially fraudulent provider behavior on the part of individual providers. Additional data will enable a comprehensive analysis of providers and provider types over a wide range of diagnoses.

This project will produce savings in at least two ways:

o Voluntary Change of Aberrant Behavior

The Department plans to use analyses produced by the system to identify providers with practice patterns outside norms. Providers would be educated on their aberrant behavior, highlighting treatment pattern variations among peer groups by diagnosis. An initial study conducted for the Department indicates radiologists often bill the more expensive office procedure fee which includes reimbursement for overhead, when services are provided in a hospital. Previous studies indicate that, after initial resistance, providers respond in a pragmatic fashion to objective data. The Department will monitor these providers' subsequent practice patterns to determine if aberrant behavior still exists.

o Regulatory Changes

Regulation changes would target areas in which it is clear that providers are continuing to provide services in excess of actual client needs. Provision of laboratory services can often vary between providers and among geographical regions. Some of the regulatory changes that could be considered include expansion of second opinion requirements (establishing second opinion requirements for specific diagnoses), and service frequency and prior approval limitations (establishing regulations that limit service frequency based on statistical norms and require providers to obtain prior approval before furnishing services in excess of those norms).

In FY87, the Department proposes to analyze practice patterns across all provider types and achieve \$10 million in savings.

The Provider Practice Pattern Analysis project will also analyze current Medicaid provider reimbursement practices for comparability with other states' and private insurers' reimbursement rates. When justified, the Department will seek increases in reimbursement rates for various provider types to more competitive levels if it can be demonstrated that such action will significantly improve access and quality and reduce providers' incentive to furnish more services than necessary. Offering providers competitive reimbursement rates may provide an incentive to enroll in Medicaid, thus increasing recipient access.

ACCESS AND PROGRAM OPERATIONS

Staff funded through this account are also responsible for the efficient management of the Medicaid program, including adequate provider enrollment, appropriate levels of reimbursement, and efficient management of day-to-day operations. Increasing recipient access to health care services is dependent to a large degree upon how well the program performs these functions.

Outlined below are several units which perform these functions.

A. Provider Relations

This unit maintains provider enrollment files and fee schedules; manages prior approval and second opinion applications for procedures subject to those requirements; and provides technical assistance to providers and the Department's claims processing agent regarding billing problems. Staff also work with providers to solve problems discouraging participation of critical providers in the program. Additionally, staff develop and update regulations governing policy and billing regulations and certify providers for participation in Medicaid.

B. Project Development

This unit is responsible for developing more cost-effective and better quality programs for Medicaid recipients, particularly the elderly, disabled, mentally ill, and mentally disabled, and for coordinating these efforts with other agencies. Staff perform several functions which address the cost-effectiveness of the Medicaid program and the quality of services, including: analysis of Medicaid rates proposed by the Rate Setting Commission, the expansion of community-based alternatives to institutional care for the elderly and disabled, volume purchasing of medical supplies and services, and coordination of health care policy with other state agencies.

HEALTH CHOICES

One of the Department's top priorities is to ensure access to quality, appropriate, cost-effective health care services for the poor. Despite Medicaid's success in generally broadening the availability of medical care coverage for the low-income population (elderly, disabled, and families), both nationwide and in the Commonwealth, there is a developing consensus that the current fee-for-service bias of the Medicaid delivery system effectively thwarts achievement of this basic goal, to the detriment of the health and welfare of poor people. This account includes funding which allows the Department to begin to address this issue.

The program's present fee-for-service system does not ensure the provision of high-quality care in a cost effective fashion. Specifically:

- o quality - because there is not ironclad guarantee that indigent people will be able to secure the services of a personal physician or primary care team, the system fails to consistently ensure continuity of care. Even in situations where the recipient is able to secure a personal physician, the fee-for-service system does not ensure comprehensive and continuing care, in part due to the absence of quality assurance monitoring.
- o access - in areas with low Medicaid provider participation rates, fee-for-service does not ensure the provision of necessary and appropriate services.
- o cost - the fee-for-service system does not ensure the delivery of appropriate services in a cost-effective fashion.

This account includes funds for the Department's initial efforts to restructure the existing Medicaid program, from a predominantly fee-for-service based system to a three-pronged system designed to better ensure comprehensive, high-quality care delivered in a more cost effective treatment setting.

The Health Choices program would initially be provided to Medicaid families and children. The goal is to offer that population access to the same health care choices as are available to other Massachusetts citizens. Recipients will have the opportunity to select their health care coverage from one of three plans:

- o Private Insurance Program - under a negotiated agreement between the state and one or more prospective private insurers, a new option for Medicaid-eligible families would be a private insurance plan such as Blue Cross Master Health Plus of Prudential Care.
- o Basic Medicaid - a revamped fee-for-service reimbursement system which incorporates generally accepted utilization control measures.
- o Coordinated Health Program - a single primary care provider (i.e., community health center, health maintenance organization, or physician) which provides or authorizes all necessary health care services.

Given the administrative complexity of converting existing provider billing and delivery systems to a coordinated health program, the Department is requesting funds in this account to fund initiatives designed to increase the availability of coordinated primary health care services. The Department would award a set of grants to providers, primarily in areas with both a high concentration of Medicaid recipients and a shortage of physicians, who agree to manage health services for Medicaid recipients. The grants would provide financial support to enable providers:

- o to defray the significant administrative start-up costs of the new programs (i.e., data processing, market analysis, 24-hour coverage);
- o to increase capacity and enrollment in existing programs, and to develop additional support services such as bilingual service and nursing coverage; and
- o to develop health screening programs for Medicaid recipients, programs designed to identify chronic or recurring health problems and to encourage ongoing treatment and prevention.

FY87 REQUEST

The Department requests \$18.4 million in administrative resources in order to achieve not only \$42 million in new FY87 savings but also to maintain ongoing savings totalling \$220 million. In addition, this account will provide resources to support three other key Department objectives --- access as promoted through efficient program management, development of Health Choices, and improvements in the long term care system.

<u>Subsidiary</u>	<u>Component</u>	<u>FY87 Request</u>
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01	Personnel	\$ 1,046,393
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02	Personnel	\$ 2,096,726
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Funds requested in these subsidiaries support 108 full time positions.

03	Management and Savings Initiatives	\$13,192,865
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This subsidiary funds personnel responsible for the management of the Medicaid program and savings agenda; the pre-admission screening program; Provider Practice Patterns Analysis project; and Health Choices.

14	Postage	\$ 1,779,870
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This subsidiary funds the costs of mailing Medicaid vendor checks, Medicaid ID cards and other MMIS mailings.

15	Equipment	\$ 319,804
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This subsidiary funds costs associated with office automation for the Medical Division.

TOTAL REQUEST		\$18,435,658
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MEDICAID MANAGEMENT INFORMATION (MMIS) SYSTEMS (4400-1012)

	<u>FY84</u>	<u>FY85</u>	<u>FY86</u>	<u>FY87 REQUEST</u>
Expenditure/ Appropriation	--	--	12,200,000	13,424,000

This account was created by the legislature in FY86 to fund the operations of and enhancements to the Medicaid Management Information System (MMIS), the Department's claims processing and provider payment system. MMIS is itself both a critical component of the Medicaid savings agenda, having saved more than \$56 million in its first 12 months of operations, and an important component of systems support for the Medicaid savings agenda. In FY87, MMIS will contribute \$4.6 million directly to the Medicaid savings agenda through edit enhancements to the system. In addition, it will provide support critical to the achievement of other savings initiatives totalling \$31 million in FY87.

A key agency goal is to deliver services and benefits to the Commonwealth's eligible individuals and families in a timely and efficient way. MMIS supports this goal by processing approximately 20 million Medicaid claims annually, representing total expenditures of approximately \$1.2 billion. Given the size and volume of the Medicaid program, errors in recipient eligibility, claims processing and payment, and provider payment and eligibility can prove costly to the Department and the Commonwealth's taxpayers. MMIS is an essential management control, ensuring that Medicaid payments are made quickly and accurately.

MMIS also functions as a management tool offering technical system support to other savings activities, such as third party liability, provider review and sanctions, and provider and recipient utilization review and control measures. Managers request from MMIS, through "change orders", data reports and analyses of provider and recipient utilization and billing patterns. Change orders either lead directly to savings or are used to highlight areas in which new Medicaid savings can be generated.

MMIS OVERVIEW

The Medicaid Management Information System (MMIS) uses the Department's Financial Management and Control System (FMCS) eligibility files to verify Medicaid recipient eligibility and process 20 million claims from over 23,000 different medical providers. MMIS was designed to capitalize on a more technically sophisticated manner of storing data, a data base management system.

A data base management system increases flexibility and speed in retrieving data, both of which are important in the ongoing operation of MMIS. Such improved data processing capabilities allow:

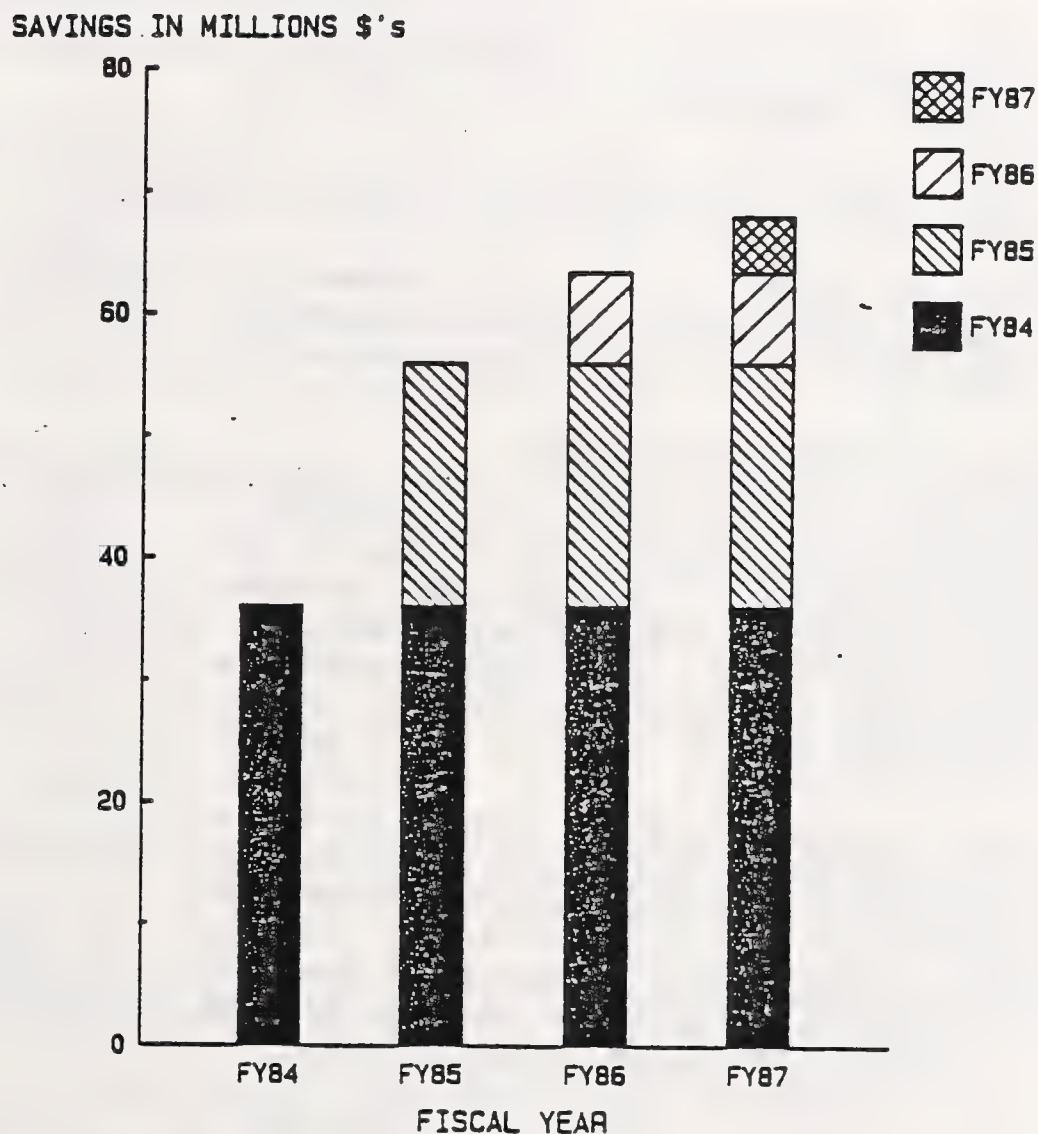
- o incorporating new policies and legislation on an ongoing basis;
- o updating recipient eligibility data rapidly;
- o special ad hoc and ongoing reports supporting agency management decision-making; and
- o analyzing provider billing practices to review provider practice patterns.

The implementation of MMIS has consolidated the processing of all claims into one facility. Previously, Medicaid claims were processed through an antiquated three-tiered system with few edits and minimal management reporting capabilities. Moreover, while the previous claims processing activities were only eligible for 50% federal reimbursement, the federal government provided 90% reimbursement for MMIS development expenses and provides 75% reimbursement for annual operational expenses, including claims processing. Thus, while the gross administrative cost of using MMIS is higher, the net state cost after federal reimbursement is in fact lower than if the Department had maintained its prior claims processing systems.

BENEFITS OF MMIS

MMIS is a key component of the Medicaid savings agenda, which will total \$262 million in new and continuing savings in FY87. MMIS denies twice as many claims as its predecessor, a computer system which possessed only the most basic edit criteria. During its first year of operation, MMIS saved the Department \$56 million, and is projected to save an additional \$12 million (above and beyond the \$56 million base) in FY86 and FY87 due to new edits and enhancements. Adequate funding in this account is needed in order to maintain the current level of savings, as well as to achieve the new savings initiatives.

MMIS SAVINGS FY84 - FY86



MMIS contributes to the Medicaid savings agenda in two areas, reduction in payment of inappropriate claims, and as technical support for Medicaid savings initiatives.

A. Savings Due Directly to MMIS Edits

o Reduction in Duplicate and Inappropriate Claims Paid

MMIS includes editing capabilities designed to detect and disallow inappropriate claims, resulting in savings. Specifically:

- The system does not pay a duplicate bill while the original bill is in process (providers often submit a second claim before the first one is processed).
- The system does not pay for services that are not Medicaid-reimbursable, such as follow-up visits if payment for surgery also included payment for follow-up care.
- The system identifies providers who submit claims for excessive numbers of patients treated in one day.
- The system does not allow payment for second once-in-a-lifetime procedures, such as two appendectomies or pulling the same tooth twice for a single recipient.

o Reduction in Fraud and Abuse

MMIS has enabled the Department to improve identification of providers who are billing the Department in error, providing services inappropriately, or deliberately attempting to defraud the Commonwealth. This additional information has improved the effectiveness of the Medical Division's provider review and professional review units and the Attorney General's Medicaid fraud unit. MMIS provides a number of specific benefits in this area, including:

- The system assigns the correct fee for each medical procedure, such as for a hospital outpatient visit which may have been billed at the higher emergency room rate.
- The system stops payments for patients who are no longer covered, such as those who are deceased, those who have left the state, or those who are no longer eligible for Medicaid.
- The system identifies physicians who bill for examining the entire family when only one individual may have needed care.

MMIS has dramatically improved the Department's ability to identify cases of potential provider fraud and abuse. The Department's Provider Review and Sanction Unit refers cases of possible fraud to the Attorney General's Medicaid Fraud Control

Unit (MFCU). MFCU is currently investigating 100 cases of potential fraud as a result of PRSU referrals.

- o Third Party Liability

MMIS has significantly improved the Department's ability to record and maintain accurate and complete insurer information on all recipients identified as having private insurance coverage, increasingly through an absent parent. MMIS has also improved identification of Medicaid claims already paid, for which other insurance coverage existed and for which the Department may therefore legally seek recovery from other insurers. Thus, as mandated by federal law, the system assures that Medicaid is the payer of last resort for recipients who have dual insurance coverage and rejects a bill if Medicare, Blue Cross/Blue Shield, Aetna or another insurer should have paid the claim.

B. Support for Other Savings Initiatives

- o Timely and Extensive Management Information

MMIS includes a subsystem which produces an extensive set of management reports. These reports provide detailed expenditure and utilization information, as well as statistics on providers, recipients, and claims processing. This information has improved the Department's ability to forecast future Medicaid costs and to evaluate the impact of policy decisions, as well as provided critical information to design and implement savings initiatives, some of which are described below.

- o Utilization Control

MMIS provides considerably more reliable and extensive information than did the prior claims processing systems regarding provider and recipient utilization patterns. This information generated from MMIS, through change orders, will enable staff to critically examine utilization patterns to determine if Medicaid provider and recipient utilization is consistent with norms.

In summary, MMIS will play a key role in maintaining base Medicaid savings of \$220 million, while also supporting new FY87 saving initiatives totalling \$42 million. The achievement of the FY87 savings agenda is dependent upon MMIS enhanced edit capabilities and report production and analyses, particularly in the following areas:

- o claim detail reporting for audit purposes;
- o more stringent edit criteria;
- o health care procedure code conversion;
- o outpatient department utilization;

- o review of provider practice patterns; and
- o technical support for such savings initiatives as pre-admission screening.

HOW CLAIMS ARE PROCESSED

The implementation of MMIS increased the speed and efficiency of claims processing and payment. The payment process begins when medical providers render services to Medicaid recipients and submit the appropriate claim forms to the Systems Development Corporation (SDC), the contractor responsible for MMIS operations. The Department pays about 44 cents for each claim processed. SDC has a strong financial incentive to either pay, deny, or suspend claims quickly, since the Department's contract with SDC specifies that claims processing fees drop sharply once the claim is more than 30 days old. In fact, the Department pays SDC nothing for claims which SDC takes 45 or more days to process. As a result of this contract provision and the improved capabilities of MMIS, providers receive payments considerably faster under MMIS than under the predecessor claims processing systems -- over 95% of claims are processed within 30 days.

SDC logs the claims in, screens them for recipient eligibility, and checks that the medical provider's signature is on the form. At this point, SDC workers microfilm the claims and send them to data entry personnel who transfer the information from the paper document to the system's mainframe computer. The paper documents are then sent to storage, and the microfilm copy of the claims enters the processing cycle.

Processing subjects the claims to several hundred computerized edit checks to assure the following:

- o validity of claim submission;
- o correct billing information;
- o correct interpretation of Department policy;
- o provider and recipient eligibility; and
- o procedures billed for are covered services.

The claims that pass all the edit checks described above are held until the financial check-writing cycle is executed over the following weekend. The system denies or flags questionable claims, sending some to the Department for such things as manual pricing or medical review.

At various points during the processing cycle, certain randomly selected claims are temporarily suspended and reviewed as a check to see if the data have been transmitted from paper to computer correctly. After this check, the system submits claims to a weekly check-writing cycle. Claims that contain "fatal" errors are marked to deny payment. When these claims reach the financial check-writing cycle, the system does not

produce a check. Fatal errors can range from billing errors to a medical procedure not reimbursable under current Medicaid policy.

The weekly financial cycle produces checks and account activity schedules for each provider owed a payment or notification of claim denial. SDC then mails these items to providers, usually by Wednesday of the following week, and then generates reports and stores the information used to process these claims for future use and reference through its Surveillance and Utilization Review (SURS) and Management Reporting (MARS) subsystems.

FY87 REQUEST

<u>Subsidiary</u>	<u>Component</u>	<u>FY87 Request</u>
(03)	MMIS contract	\$12,047,000
(03)	Personnel	<u>1,387,000</u>
..	TOTAL REQUEST	\$13,434,000

This account funds both the contract with SDC to operate MMIS, and agency technical personnel assigned to MMIS management.

The staff assigned to manage MMIS perform the following functions:

- o detailed and monitoring of the performance of SDC;
- o helping to design the specifications of change orders, and then holding SDC accountable for completing the work as specified on time;
- o providing technical support to other agency staff responsible for designing and implementing savings initiatives which rely on MMIS. In FY87, these include provider practice pattern analysis, pre-admission screening and third party liability and total to \$26 million; and
- o developing new claims processing edits to generate new savings.

FEDERAL REIMBURSEMENT FOR DEPARTMENT PROGRAMS

The federal reimbursement received by the Department of Public Welfare is essential if the state is to maintain a balanced budget. The Department returns an estimated 45% of its total expenditures to the General Fund in the form of federal revenue, reducing the net state cost of agency operations and programs to about 55% of the Department's appropriation. The Department's FY87 request totals \$2.214 billion, an increase of only 5.6% over projected FY86 spending. The agency anticipates \$947.7 million in federal reimbursement to partially offset this projected spending.

In addition to obtaining reimbursement for the Department's expenditures, the Department has been instrumental in securing revenue for other state agencies. The Department has been designated as the single state agency for state Medicaid programs. This enables the Welfare Department to claim reimbursement for certain costs at the Department of Mental Health (DMH) and the Department of Public Health (DPH) for their Medicaid-eligible clients. These funds are deposited in the revenue receipt accounts of these agencies, crediting them with the funds received. In SFY85, the Welfare Department received and deposited \$113 million in the DMH accounts, and \$14 million in the DPH account, a significant benefit to the state's balance sheet.

Since FY84, federal revenue has increased by 23% from \$766.0 million in FY84 to a projected \$947.7 million in FY87. At the same time, cutbacks in federal reimbursement have forced Massachusetts to assume a larger share of the costs of providing assistance, and this trend is likely to continue at least through the Reagan administration. State-funded programs that the Department has implemented to replace assistance that had previously been federally reimbursed include: the Grant for Education and Training (GET) program, to provide assistance to 19 to 21 year-old low-income dependents in school; supplemental payments to working AFDC recipients whose income has decreased; and AFDC assistance to pregnant women for the full term of pregnancy. This trend has necessitated a greater effort by the Department to aggressively pursue federal reimbursement for those programs in which the federal government still participates.

THE FEDERAL REIMBURSEMENT PROCESS

Although federal funds can be utilized by the state in two ways, as reimbursement for state expenditures, or as a federal grant, almost all of the federal funds received by the Department of Public Welfare are received as federal reimbursement for state expenditures. These funds are credited as revenue to the state's General Fund, and offset the costs of the Department's operations.

The Department receives federal reimbursement from two federal agencies: the Department of Health and Human Services and the Department of Agriculture. The Department of Public Welfare receives federal funds through a system of quarterly awards. Each of these federal oversight agencies awards funds based on a Department estimate of what the

reimbursable expenditures will be for a given quarter. Funds are then drawn from the Federal Reserve Bank and are credited to the state's General Fund based on these awards. The awards are then compared to the Department's claims for expenditures, which are sent to each federal agency thirty days after the end of the quarter. An over- or under-award is then adjusted in a future quarter.

A. Reimbursement for Program Expenditures

The Department receives federal reimbursement for most of its expenditures, with the exception of General Relief program expenditures, payments to the Social Security Administration for the state supplement to SSI recipients, and certain legislatively mandated programs, such as Family Reunification Benefits, second emergency assistance payments in the case of natural disaster and homelessness, and assistance to the homeless. All other types of expenditures are reimbursable at rates between 50% and 100%. If the non-reimbursable accounts (SSI and GR) are excluded, federal revenue averages between 50% and 51% of the remaining welfare appropriation.

The largest source of program revenues is the Department of Health and Human Services (HHS). HHS reimburses the state for grants to recipients of Aid to Families with Dependent Children (AFDC) and for payments to providers of Medicaid services. The federal share of these payments is determined by the Federal Financial Participation (FFP) rate.

The basic FFP rate for these program expenditures is currently 50%. This rate is determined by a formula which compares the per capita income of a state to all other states. States with higher per capita income receive less federal support. The FFP rate is recomputed every two federal fiscal years (FFY), and cannot be lower than 50%. The FFP rate decreased from 53.56% to 50.13% on October 1, 1983, and to 50% on October 1, 1985. This continuing decrease reflects the increasing strength of the Massachusetts economy relative to other states, but it is costing the Welfare Department about \$50 million per year in federal reimbursement.

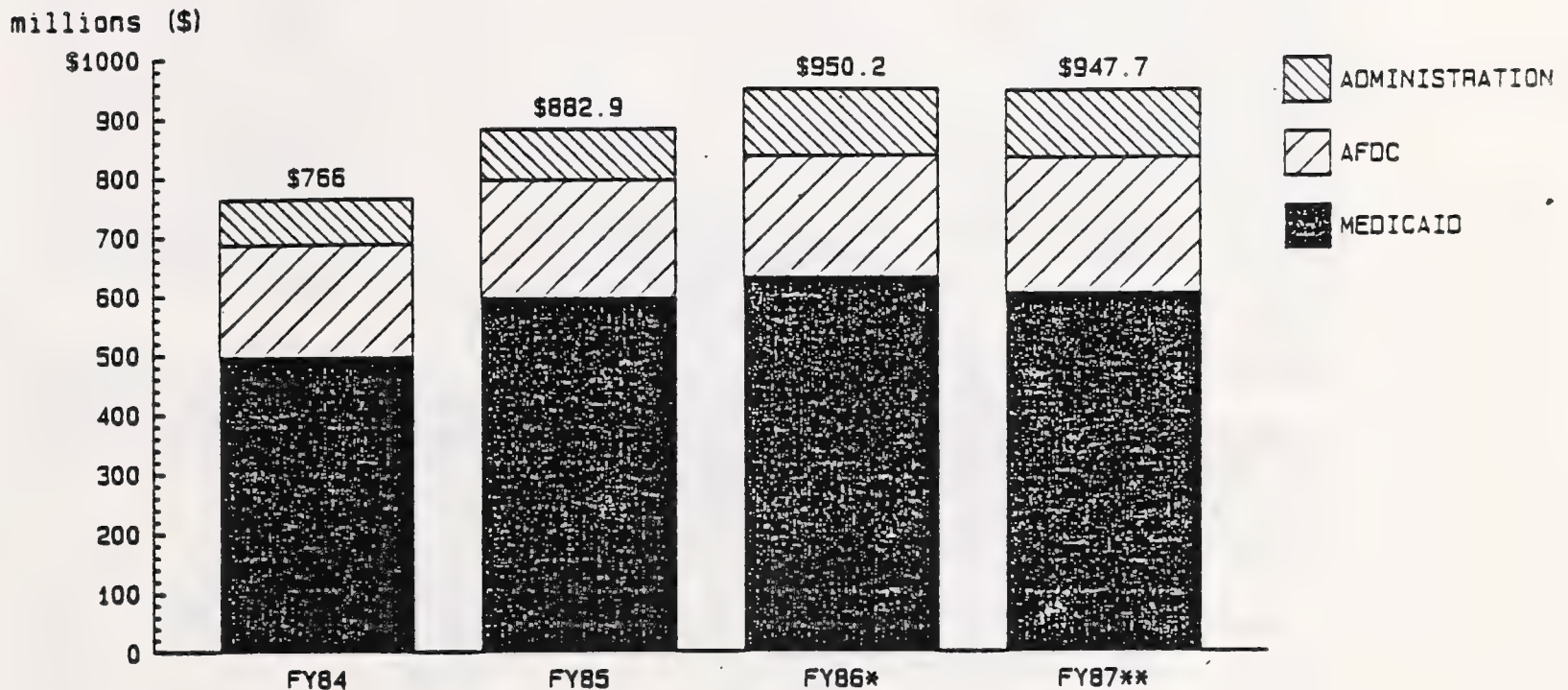
Although the basic FFP rate applies to most program expenditures, some payments are reimbursed at different rates. For example, payments to eligible refugees are reimbursed at 100% by the federal government, family planning expenditures are reimbursed at 90%, and emergency assistance payments are reimbursed at a flat 50%.

FEDERAL REIMBURSEMENT FOR PROGRAM EXPENDITURES

1. Refugee	100%
2. AFDC	50%
3. Medicaid	50%
4. General Relief	0%

The chart below shows federal reimbursement returned to the General Fund as revenue by the Department for state fiscal years (SFY) 1984 to 1985, along with projections for SFY86 and FY87.

FEDERAL REVENUE FY84-FY87



<u>Program</u>	<u>SFY84</u>	<u>SFY85</u>	<u>SFY86*</u>	<u>SFY87**</u>
AFDC	188.7	197.6	204.3	227.7
Medicaid	500.7	599.2	633.5	606.7
Administration	76.6	86.1	112.4	113.3
	766.0	882.9	950.2	947.7

*estimated (includes \$13.2M in Federal reimbursement accounts)

**estimated (includes \$14.9M in Federal reimbursement accounts)

As the above tables show, although the Welfare Department receives most of its federal revenue as reimbursement for program expenditures, the Department also receives a substantial amount of revenue for administrative costs.

B. Reimbursement for Administrative Expenditures

In addition to the reimbursement for program expenditures, the Department receives reimbursement for much of its administrative costs. Because many of its administrative costs are shared by several programs, the costs are distributed to the appropriate program through the Department's federally approved Cost Allocation Plan. The Department determines whether costs are direct costs that are program-specific, or indirect costs which are applicable to more than one program. Thus, the salary and fringe benefit costs of a child support worker are fully charged to the federal Office of Child Support Enforcement, while a local office director's salary goes into the Department's indirect cost pool. This indirect cost pool is then charged to the various programs based on the percentage of overall direct costs charged to a specific program. For example, if the Child Support program was responsible for 10% of the Department's direct costs, it would be also charged 10% of indirect costs. This plan, prepared by the Department and approved by the HHS Division of Cost Allocation, determines each program's share of total administrative costs.

Although administrative expenditures are reimbursed at a basic rate of 50%, the Department receives enhanced funding in several areas. The following table depicts the reimbursement rates for the Department's administrative costs:

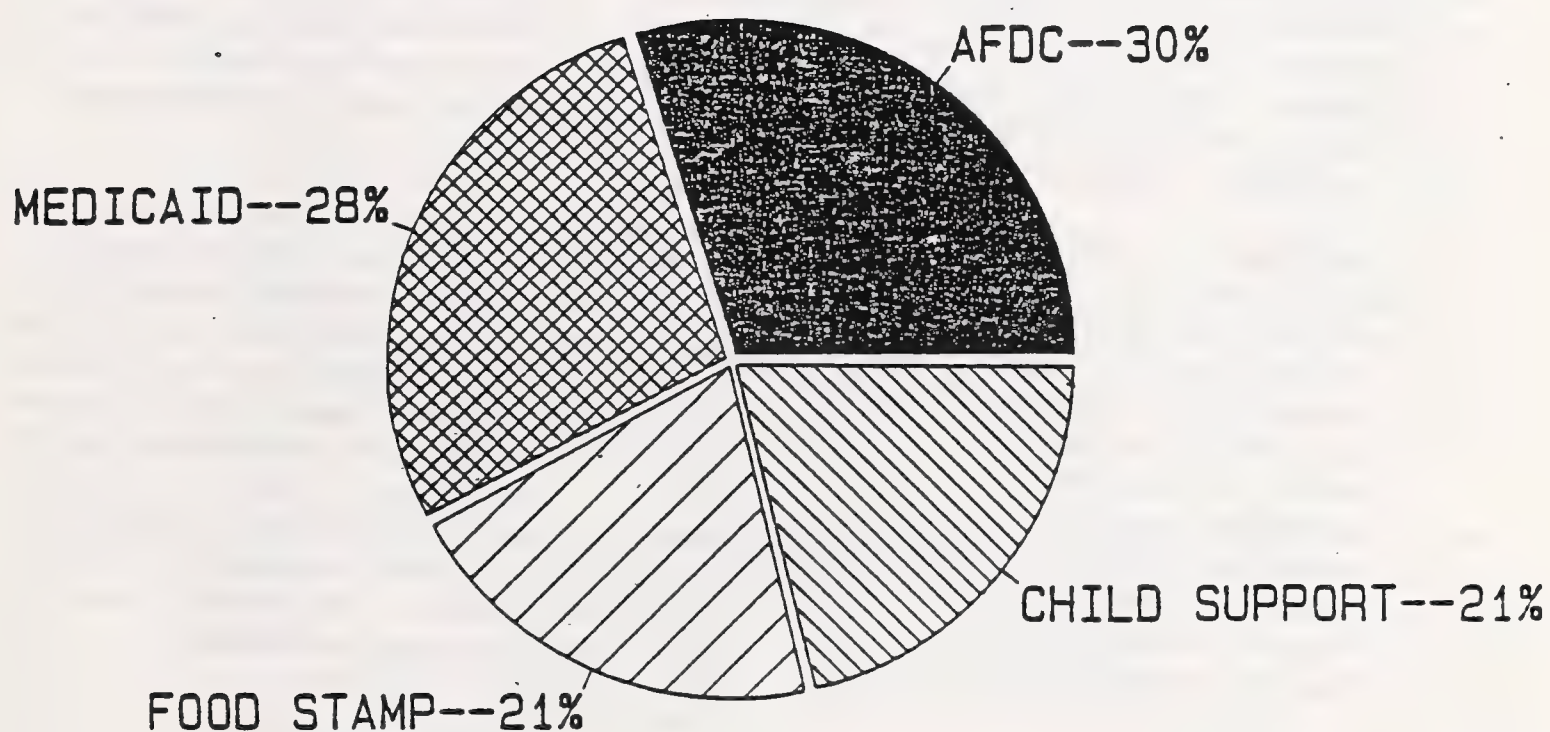
<u>FEDERAL REIMBURSEMENT FOR ADMINISTRATIVE EXPENDITURES</u>		
1. Refugee Resettlement		100%
2. Systems Development	75 -	90%
3. MMIS Operations		75%
4. Medical Professionals and Project Good Health		75%
5. BSI Food Stamp Fraud Investigations		75%
6. Child Support		70%
7. BSI AFDC and Medicaid Fraud Investigations		50%
8. AFDC, Medicaid, and Food Stamps		50%
9. General Relief*		10%

As shown in the table above, in addition to the reimbursement received on Departmental costs, the state receives reimbursement, through the Welfare Department's claims, for certain administrative costs of other agencies. These reimbursed costs include costs incurred by the probate and district courts for child support activities, Bureau of Special Investigation costs related to fraud investigations, Rate Setting Commission operations costs, Office of

*Administrative costs attributable to the General Relief program are reimbursed at 10%, as one-fifth of these costs are charged to the US Department of Agriculture which reimburses them at a 50% rate.

Management Information Services costs for computer operations, and Department of Public Health costs for utilization review programs. The following chart shows the Department's administrative revenue for SFY85, by program:

ADMINISTRATIVE REVENUE SFY85



	<u>FY85</u>
AFDC Administration	\$25.7M
MA Administration	\$24.1M
Food Stamp Administration	\$17.9M
Child Support Administration	\$18.4M
	<u>\$86.1M</u>

C. Federal Review

The Department operates its programs under approved state plans, which are comprehensive statements that the Department submits to federal agencies describing the nature and scope of its programs. The state plan contains all information necessary for the federal agency to determine whether it can approve the Department's claim for federal financial participation. The plan identifies the types of services covered and the groups of clients aided. It is updated and changed as programs change.

The federal agencies have two basic methods of sanctioning states for failure to comply with the state plan, failure to comply with federal regulations, or overclaiming costs. These methods are the disallowances (or deferrals) and Quality Control reviews. A disallowance or refusal to reimburse occurs most often in cases involving administrative reimbursement, especially in the areas of systems development and data processing purchases, and in Medicaid claims, especially claims regarding clients in public institutions, where the state Rate Setting Commission's methodology for determining cost comes under close scrutiny.

The Quality Control process, in comparison, is a statistical review, comparing the state's error rate, which is derived by reviewing a random sample of cases, to a federally determined target error rate. If the state's error rate is higher than the target, the agency is subject to a monetary sanction. Over the past several years, through an ambitious agenda of error reduction efforts described in more detail elsewhere in this volume, Massachusetts has been successful in avoiding Quality Control sanctions. The only Quality Control sanction which has ever been assessed is a \$1.4 million prospective (based on estimated error rate) Medicaid sanction, assessed in FY84. Even in that single case, it is possible that the state will receive the money back when the actual error rate has been determined.

CHANGES IN FEDERAL REIMBURSEMENT -- IMPACT ON MASSACHUSETTS

During the last five years, there have been several federal attempts to either reduce services to the poor, or shift the cost of those services to the states.

The federal government's efforts in this area vary by program. Reductions in federal participation in the AFDC program take the form of narrowed program eligibility, eliminating the reimbursement for recipients in certain circumstances. States must then decide whether to aid these recipients in a fully-state funded program. In each of these cases, Massachusetts has chosen to aid recipients who would otherwise receive no aid under restricted federal guidelines. Reductions in Medicaid and administrative reimbursement tend to take the form of either a penalty if reimbursable expenditures grow by more than a target rate, or a reduction in the FFP percentage for a specific program. The federal changes that have reduced the state's revenue are:

- o In the AFDC program, the 1981 federal policy changes in the Omnibus Budget Reconciliation Act (OBRA) eliminated eligibility for 19 to 21 year-old low-income dependents, regardless of their educational status. Massachusetts opted to provide state assistance to these recipients, and established the Grant for Education and Training (GET) program, at a state cost of \$300,000 per year. Through this program, the state aids more than 250 students each month to complete their secondary education. OBRA also eliminated AFDC in the first two trimesters of pregnancy for pregnant women with no other dependents. Again, the state responded in Chapter 398 of the Acts of 1984 by extending aid to this vulnerable population at full state cost. More than 1,000 pregnant women currently receive aid under this program.
- o In Medicaid, the reduction in federal funding took the form of a percentage reduction in basic Medicaid reimbursement for federal fiscal years (FFY) 1982, 1983 and 1984. These base percentage reductions totalled 3% in FFY82, 4% in FFY83 and 4.5% in FFY84, with Massachusetts qualifying for one percentage point relief in these penalties because the state has a qualified hospital cost and rate-setting review program. The federal reductions for FFY82 and FFY83 cost the state a total of \$36.5 million in Medicaid revenue. If the Medicaid reimbursement in a given year increased less than the increase in the index of medical care in the Consumer Price Index, a state could receive a rebate of up to the full amount of the sanction. Because of the Department's ability to control Medicaid expenditures, the state has received a full refund of the FFY84 reduction.
- o The Federal Office of Refugee Resettlement (ORR), which provides 100% reimbursement for cash and medical assistance provided to refugees, has reduced the scope of its program by instituting time limits on the duration of this reimbursement. ORR will now provide 100% reimbursement only if a refugee has been in the country less than 37 months (if the refugee is eligible for AFDC or General Relief) or less than 19 months (if the refugee is not eligible for these programs). The Department has implemented a new Refugee Education and Employment Program in order to extend employment and training services to refugees, with the goal of full self-sufficiency before this time limit.
- o The Federal Office of Child Support Enforcement has reduced the amount of revenue the state receives by reducing the FFP rate for administrative reimbursement from 75% to 70% on October 1, 1982, and by reducing one year later the incentive payment that states receive for collecting child support from 15% to 12% of collections. Together, these changes cost Massachusetts almost \$2.5 million per year in reduced revenue.
- o The WIN Demonstration program, which helps to fund the Department's Employment and Training Program, caps the maximum reimbursement states can receive. WIN demonstration program funding has totalled about \$8.4 million per year for each of the

last three years. In FFY85, Massachusetts would have received an additional \$7 million dollars if a reimbursement cap was not in effect. In FFY86, national WIN funding was cut by Congress, reducing Massachusetts' allocation by \$1.5 million. Although the ET program has placed more than 23,000 AFDC recipients into jobs since it began in October 1983, resulting in savings of more than \$30 million to the federal government, federal funding for the program has declined.

These reductions in federal participation have cost Massachusetts a total of about \$65 million dollars in reduced revenue over the last four years.

MASSACHUSETTS RESPONDS -- FILLING IN THE GAPS

As noted earlier, because of the reduced federal commitment to assisting low-income people, and a concomitant increase in the number of people who are falling through the federal "safety net" the Department has expanded the existing list of fully state-funded programs. These programs, designed to provide assistance to people who do not meet restrictive federally established eligibility criteria, include:

- o Supplementary payments to working AFDC recipients whose earned income has decreased or terminated, but whose grants, due to the federally mandated monthly reporting system, will not compensate for this loss for two months. This program began in FY85, and aids approximately 400 AFDC families per month.
- o Family Reunification Benefits designed to provide assistance to mothers whose children have been temporarily placed in foster care. This assistance provides funds totaling about \$400,000 per year to families preparing for the return of these children.
- o Second Emergency Assistance (EA) payments. The Department provides for additional EA payments in the event of natural disaster or homelessness. Federal regulations only allow one EA 30-day period per year.
- o Grant for Education and Training (GET). The GET program provides assistance to approximately 250 19 to 21 year-old dependents each month with the goal of allowing low-income students to complete secondary education. OBRA made these students ineligible for AFDC.

- o Aid to Pregnant Women. Legislation to restore aid to pregnant women during the first six months of pregnancy was enacted by the legislature last year and signed by the Governor. This assistance totals an estimated \$4 million in FY87 and currently aids 1,000 pregnant women.
- o ET Choices. The Department has responded to the federal job search requirement for AFDC recipients by developing an innovative program which provides a choice among a number of options, including education, training, supported work, and job placement. In addition, the Department funds day care for participants in the Employment and Training Program at an estimated cost in FY87 of \$21.5 million.

These state-funded programs, needed to fill in the gaps caused by restricted federal participation, cost Massachusetts an estimated \$28 million per year.

INITIATIVES TO INCREASE REVENUE

The state has also responded to federal policy changes by maximizing revenue for programs that are still federally reimbursable. The agency has developed an ambitious agenda of initiatives, which includes:

A. Enhanced Funding for Systems Development.

The federal government authorizes, upon approval of an Advance Planning Document (APD), enhanced reimbursement for certain types of systems development. The reimbursement rate for most programs is 90%. The Department has developed or proposed several systems which will improve management of agency programs and that should receive this enhanced federal funding, therefore involving only limited net state cost. These include:

- o MMIS. The state has received 90% FFP on the costs of developing the Medicaid Management Information System, and receives 75% FFP for the cost of operating the system. Under the previous system, the FFP rate was 50%. This enhanced funding for the operation of MMIS results in increased federal reimbursement of approximately \$3 to \$4 million per year and has produced Medicaid savings of \$56 million.
- o MPACS. The Department is currently in the final stages of negotiations with HHS and other federal funding agencies and has secured initial approval of the APD for the Massachusetts Public Assistance Control System. This approval will result in FFP of up to 85% of MPACS development expenditures. As a result, the net state cost of establishing this new computerized eligibility management system may be as little as 15% of expenditures. This project is described in detail elsewhere in this volume.

B. ET and Day Care Revenue.

Although the WIN program limits the amount of Employment and Training expenditures that it will reimburse through a reimbursement cap, the Department has developed additional sources of revenue in this area. The Department has developed management systems to track the day care and other costs of clients in employment search activities. This revenue, unlike WIN funding, is uncapped and is available at an FFP rate of 50% on all eligible expenditures. The Department collected more than \$2 million of this revenue in FY85, which was used by the Employment and Training program to provide valuable services to its clients. In addition, the Department established a system to gain AFDC revenue on supported work expenditures, producing another \$2 to \$3 million per year in federal reimbursement.

C. Expanded Medicaid-Reimbursable Services.

The Departments of Public Welfare, Public Health, Elder Affairs and Mental Health have jointly changed the scope of services for a number of health programs that are currently state funded, and restructured these programs so they will be federally reimbursable through the Medicaid program. As a result, the cost to the state for providing these medical services has been reduced. Four examples are described below.

- o Home and Community-Based Services. Massachusetts has received federal approval of its requests for three federal Medicaid waivers, which will allow the Department to receive reimbursement for home and community-based services for Medicaid-eligible clients receiving services from the Departments of Mental Health and Elder Affairs. These services, provided to individuals who would be at risk of institutionalization without such services, are now federally reimbursable at the basic FFP rate of 50%.
- o Extended Medicaid Eligibility for Working Poor Families. The Deficit Reduction Act (DEFRA) of 1984 provides for an additional 9 months (with 6 additional months at state option) of extended Medicaid coverage for AFDC families that become ineligible due to the loss of earned income disregards. This additional 15 months of Medicaid eligibility is estimated to cost \$2.4 million per year. It will produce \$1.2 million in federal reimbursement and will provide important assistance to families moving from welfare to employment and economic self sufficiency. Clients who are not eligible for this extension, and find their job through the ET program, will be covered by the ET Health program, described earlier in this volume.
- o Early Intervention Services. The Departments of Welfare and Public Health have jointly developed a proposal for early intervention services for children from birth to 3 years old who are handicapped or are considered to be at risk of becoming so due to biological or environmental factors. The medical portion of these services delivered to Medicaid-eligible recipients will be reimbursable. The Medicaid portion of these costs in SFY87 is

expected to be \$1.5 million, which will produce \$750,000 in revenue.

- o Psychiatric Service for those Under 21. Massachusetts has begun providing Medicaid-reimbursable inpatient psychiatric care in public and private psychiatric hospitals to Medicaid-eligible clients under 21 years old. This will produce approximately \$2.5 million in new Medicaid revenue annually.

D. Disputing Federal Disallowances.

The federal government has become more aggressive about disallowing reimbursement for technical differences between federal regulations and state practices. In response, the Department has appealed and successfully overturned several disallowances.

- o Grant Appeals Board. In FY85, aggressive challenges to federal decisions at the Grant Appeals Board produced \$23 million in additional revenue to the state. The Board's ruling overturned the federal Health Care Financing Administration (HCFA) interpretation of federal regulations regarding the timeliness of claims and allowed Massachusetts to receive reimbursement on claims filed in 1980 and 1981 for prior year expenditures. This additional \$23 million was divided between the Departments of Welfare and Mental Health.
- o Emergency Assistance Tracking System. The Department's ability to establish an Emergency Assistance tracking system during FY84 had enabled the agency to receive payment on Emergency Assistance claims that had been previously disallowed or deferred. As a result, the state received an additional \$9.5 million in prior year reimbursement in SFY84 and SFY85, in addition to federal funding on current eligible Emergency Assistance expenditures.
- o Bureau of Institutional Schools (BIS) Educational Costs. A recent court victory by the Department overturned HCFA's disallowance of costs incurred in the training of mentally retarded individuals in Intermediate Care Facilities for the Mentally Retarded (IFC-MR). This ruling by the federal district court will force HCFA to reimburse the state for teaching these DMH clients to clothe and feed themselves. If this decision stands, it will result in an additional \$11 million in revenue, which will be divided between Welfare and DMH.
- o AFDC - Foster Care. A joint effort by the Departments of Welfare and Social Services resulted in the filing of several retroactive claims for FY78 to FY82 foster care expenses. These claims produced \$6.5 million in additional FY86 revenue for the state.

RECENT FEDERAL BUDGET DEVELOPMENTS

A. The FY86 Reagan Budget

In February 1985, the Reagan administration's FY86 budget proposal was submitted. This proposal contained several cuts that would have further reduced federal participation in human services beyond those adopted earlier in his term. Among the proposals that would have adversely affected Massachusetts were:

- o Medicaid Reduction - The proposal would have capped Medicaid FFP at 118.9% of FFY84 reimbursement and could have cost Massachusetts up to \$35 million in federal revenue.
- o Elimination of WIN - The administration again proposed eliminating the WIN program, and replacing it with a "workfare" proposal, which would have eliminated the training programs utilized so successfully by ET clients. The loss of WIN funding would have resulted in \$8 million in additional state costs during SFY86.
- o Administrative Cap - Similar to the Medicaid cap, this provision would have limited AFDC, Medicaid, and Food Stamp administrative reimbursement to the same percentage of the national funding for these programs that was received by the state in FY84. Massachusetts could have lost an estimated \$12 million if this proposal had been enacted.
- o Refugee Assistance - The proposal would have eliminated funding for the targeted assistance grants for refugees. The Department receives \$1.3 million per year for this special program, which enables the state to administer employment and skills training programs to refugees in Middlesex and Suffolk counties.
- o AFDC Changes - The Reagan proposal sought to eliminate AFDC eligibility for parents whose youngest child is over 15 years old, and for most unmarried minor parents who move away from their parent's home.
- o Other reductions - There were also substantial cuts proposed in Federal Housing assistance that could have indirectly increased Department costs in the area of Emergency Assistance, Homelessness and emergency shelter. These cuts in public, subsidized, and low-income housing would have decreased the availability of affordable housing and would probably have resulted in increased evictions, EA payments for rent arrearages, and longer periods in emergency shelters and motels.

B. The State Response

When the administration's proposal was released, Massachusetts immediately responded to a federal budget which would have funded

increased military spending by reducing federal financial support for programs for the poor. The Department, working with the Governor's Office of Federal Relations, showed Congress that the impact of these changes would have severely limited the state's ability to meet the needs of its disadvantaged. These efforts, along with similar efforts of other states, contributed to the defeat of the proposal.

The budget that was approved by Congress did not contain any Medicaid or administrative caps, and continued the WIN program, although at reduced funding. This reduction will cost Massachusetts \$1.5 million during FFY86.

C. Gramm-Rudman-Hollings

While Congress did not approve the cuts contained in the FFY86 Reagan budget proposal, they did pass the Gramm-Rudman-Hollings Deficit Reduction Act. This law requires the federal budget to meet annual deficit targets beginning in FFY86, which will eliminate the federal deficit by 1991. (Federal budget deficit targets are \$171.9B in FFY86, \$144B in FFY87, \$108B in FFY88, \$72B in FFY89, \$36B in FFY90, \$0 in FFY91.) If Congress fails to pass a budget which meets the annual deficit target, an automatic budget-cutting process achieves the needed reductions. Although the major welfare programs, including Medicaid, AFDC, and Food Stamps, are exempt from Gramm-Rudman-Hollings automatic reductions, the Department and its clients will still be affected by the bill:

- o Direct Cuts in WIN, Refugee, and Child Support. The Department is affected directly because WIN, Refugee, and Child Support administrative reimbursement would be reduced if the automatic cuts are triggered. As the Department's Employment and Training and Refugee programs use federal funds to provide services, any reduction would require additional state funds to be appropriated to maintain the same level of services.
- o Cuts in Other Programs For the Department's Clients. The Department's clients will be hurt by Gramm-Rudman-Hollings as it triggers cuts in other federal assistance programs for low-income clients: reductions in Low Income Energy Assistance and subsidized housing reduce critical benefits available to welfare clients, as well as potentially increasing Emergency Assistance expenditures; cuts in the Job Training Partnership Act (JTPA) system reduce training opportunities for the Department's clients and could result in additional ET expenditures to compensate for these federal cuts.
- o Pressure on Congress to Cut Human Services to Avoid Triggers. The bill may exert additional pressure on Congress to accede to some of the administration's reduction proposals in order to avoid the triggering of the Gramm-Rudman-Hollings automatic cuts.

- o Pressure on State Budgets Through Reduced Federal Aid. Perhaps most significantly, Gramm-Rudman-Hollings is likely to result in reduced federal aid to states and localities, through reduced federal reimbursement, grants, and revenue sharing, creating tremendous fiscal pressure on the states' budgets and reducing states' abilities to respond to the growing needs of its poorer citizens. This financial loss to the Commonwealth will impair the state's ability to fund needed programs for low-income citizens.

D. The FFY87 Budget -- Potential Changes in Federal Support for Department Programs

The combination of the Reagan Administration's commitment to increased military spending and pressure to reduce the federal budget deficit is likely to result in further reductions in federal financial support for programs for the poor.

The administration will probably propose cuts similar to those in its FY86 proposal:

- o Medicaid - A reduction proposal, possibly similar to the FY82 OBRA sanction, or a proposal to cap reimbursement, similar to the FY86 proposal, appears likely.
- o WIN - It is likely that the administration will reintroduce a proposal to eliminate the WIN program. As the ET program uses WIN funds to provide needed services, the loss of WIN funding would result in a funding shortfall of approximately \$8 million.
- o Administration - Possibilities include caps, block grants, or elimination of enhanced funding. Caps and block grants would limit the amount of administrative reimbursement the state could receive. Elimination of enhanced funding would reduce the federal share of MMIS operations (currently 75%) and systems development (currently 90%) to a 50% FFP rate.
- o Other changes in federal participation in welfare programs- These potential changes could include the shifting of programs from joint federal and state funding to solely state funding, elimination of funding for federal programs, such as the Refugee Program, and the combining of several assistance programs into one program.

The continuing shift of federal resources away from human services will create additional pressure on the state's budget and increase the importance of both revenue enhancement initiatives and savings initiatives designed to control the costs of agency programs.

STATISTICAL APPENDIX

WELFARE CASELOADS, FY60-FY86

	AFDC			MA-ONLY				6R	SSI			FOOD STAMPS			REFUGEE		
	BASIC	UP	TOTAL	MA-DAA	MA-DA	MA-AFDC	MA-UN21		TOTAL	DAA	SSI-DA	TOTAL	PA	NPA		SSI	TOTAL
FY60			14,286														
FY61			15,990														
FY62			17,617														
FY63			19,256														
FY64			21,708														
FY65			24,191														
FY66			26,330														
FY67			29,665														
FY68	36,152	738	36,890			9,586	43,604	53,190	10,947	48,444	14,574	63,018					
FY69	44,349	1,508	45,857			10,998	41,224	52,242	13,271	49,074	15,391	64,465					
FY70	55,234	1,703	56,937			10,118	29,320	39,438	19,722	50,484	16,678	67,162					
FY71	68,831	2,185	71,016			8,749	23,450	32,199	29,423	53,166	18,951	72,117					
FY72	74,690	2,428	77,118			8,066	20,189	28,255	32,006	N/A	22,161	N/A					
FY73	81,685	2,251	83,936			7,575	19,180	26,755	25,015	N/A	25,247	N/A					
FY74	88,582	3,156	91,738			4,193	11,622	15,815	26,060	58,742	29,839	88,581					
FY75	N/A	N/A	104,066	41,500	7,510	6,400	18,548	73,958	37,692	76,775	38,814	115,589	108,903	88,006	197,061		
FY76	106,629	4,317	110,946	41,173	7,935	8,101	24,439	81,648	28,371	80,500	46,960	127,460	111,148	84,211	195,359		
FY77	110,870	5,569	116,439	41,882	8,665	8,280	20,036	78,863	21,058	76,885	52,682	129,567	114,544	73,325	187,869		
FY78	114,475	5,796	120,271	42,771	9,724	10,732	18,082	81,303	20,088	73,038	55,518	128,556	115,316	57,086	172,402		
FY79	115,999	5,076	121,075	42,664	9,439	10,664	13,037	75,804	19,925	74,742	54,123	128,865					
FY80	116,155	4,570	120,725	41,226	8,511	9,445	10,227	69,409	20,823	71,759	54,018	125,778	110,774	47,362	158,136		
FY81	117,193	5,500	122,693	41,765	8,799	8,804	8,698	68,066	21,706	66,733	53,286	120,019	114,381	41,779	156,160		
FY82	105,567	3,986	109,553	39,178	7,886	9,487	7,195	63,746	21,855	60,267	51,887	112,154	106,692	38,507	34,958	171,418	
FY83	88,176	3,179	91,355	39,589	7,527	7,563	7,916	62,595	25,019	54,739	49,152	103,891	92,229	38,303	32,737	163,340	
FY84	84,777	2,756	87,533	39,645	8,344	10,302	10,419	68,710	27,931	53,351	50,175	103,526	86,537	35,449	29,803	151,789	
FY85	82,492	1,899	84,391	38,426	8,484	10,976	10,944	68,830	26,305	54,155	51,700	105,855	81,454	31,411	29,527	142,392	
FY86	N/A	N/A	85,356	38,460	8,570	8,640	9,819	65,489	24,869	52,834	54,678	107,512	80,194	30,626	30,156	140,976	

*Represents caseload estimates reflected in August spending plan.

DECEMBER 1985 AFDC AND GR CASELOADS BY LOCAL OFFICE

	<u>Local Office</u>	<u>AFDC Caseload</u>	<u>GR Caseload</u>
Boston	East Boston	1447	476
	Church Street	1718	755
	Roxbury Crossing	3587	868
	Hancock Street	2687	632
	South Boston	1153	462
	Roslindale	3998	817
	Central Boston	0	459
	Halfway House Unit		
	Grove Hall	3375	766
Springfield	Adams	805	280
	Chicopee	1112	319
	Great Barrington	145	30
	Greenfield	1363	411
	Holyoke	2596	883
	Northampton	703	300
	Palmer	379	99
	Pittsfield	1290	408
	Springfield	7423	3393
	Westfield	1331	411
Worcester	Fitchburg	1718	356
	Milford	966	167
	Southbridge	1569	332
	Gardner	731	201
	Worcester	4738	1267
Lawrence	Beverly	372	85
	Chelsea	1931	470
	Gloucester	504	101
	Haverhill	1193	346
	Lawrence	3475	775
	Lowell	2893	743
	Lynn	2743	891
	Malden	1689	499
	Newburyport	144	58
	Salem	1006	334
	Wakefield	376	90

	<u>Local Office</u>	<u>AFDC Caseload</u>	<u>GR Caseload</u>
Greater Boston	Cambridge	1283	372
	Acton	187	64
	Framingham	691	214
	Norwell	143	56
	Marlborough	127	125
	Newton	891	344
	Norwood	581	228
	Quincy	1304	349
	Somerville	1178	422
	Waltham	595	164
	Weymouth	650	162
	Woburn	463	102
New Bedford	Attleboro	859	297
	Barnstable	755	144
	Brockton	3664	972
	Fall River	2949	788
	Falmouth	551	123
	Nantucket . .	21	11
	New Bedford	3679	1055
	Oak Bluffs	53	18
	Orleans	217	65
	Plymouth	1085	189
	Taunton	1329	317
	Wareham	495	72
TOTAL		85,210	25,140*

* Total includes 257 GET (Grant for Education and Training) recipients.

DEPARTMENT OF PUBLIC WELFARE LOCAL OFFICES



MONTHLY GRANT LEVELS AND ELIGIBILITY STANDARDS

AFDC

<u>Family Size</u>	<u>Payment Standards</u>	<u>Standard of Need</u>	<u>185% Eligibility Standard</u>
1	\$282	\$287	\$ 531
2	358	365	675
3	432	439	812
4	505	515	953
5	579	591	1,093
6	654	667	1,234
Incremental	76	76	141

One-time clothing allowance of \$125 per dependent granted in September 1985.

GR

<u>Family Size</u>	<u>Full Cost of Living</u>	<u>Shared Living Expenses</u>	<u>No Household Expenses</u>
1	\$244.40	\$162.10	\$ 74.60
2	318.10	235.80	148.30
3	391.80	309.50	222.00
4	465.50	383.20	295.70
5	539.20	456.90	369.40
Incremental	73.70	73.70	73.70

Recipients living in institutions receive a personal needs allowance of \$55.00.

One-time clothing allowance of \$90 per recipient granted in September 1985.

MEDICAID-ONLY

<u>Family Size</u>	<u>Income Eligibility Standard</u>
1	\$440
2	483
3	497
4	509
5	584
6	660
Incremental	76

MONTHLY FOOD STAMP STANDARDS
(Effective 10/1/85)

Monthly Gross Income Standards

<u>Household Size</u>	<u>Maximum Allowable Monthly Gross Income</u>
1	\$569
2	764
3	959
4	1,154
5	1,349
6	1,544
7	1,739
8	1,934
For each additional member add	195

Monthly Net Income Standards

<u>Household Size</u>	<u>Maximum Allowable Monthly Net Income</u>
1	\$438
2	588
3	738
4	888
5	1,038
6	1,188
7	1,338
8	1,488
For each additional member add	150

Maximum Monthly Coupon Allotments

<u>Household Size</u>	<u>Maximum Allotment</u>
1	\$80
2	147
3	211
4	268
5	318
6	382
7	422
8	483

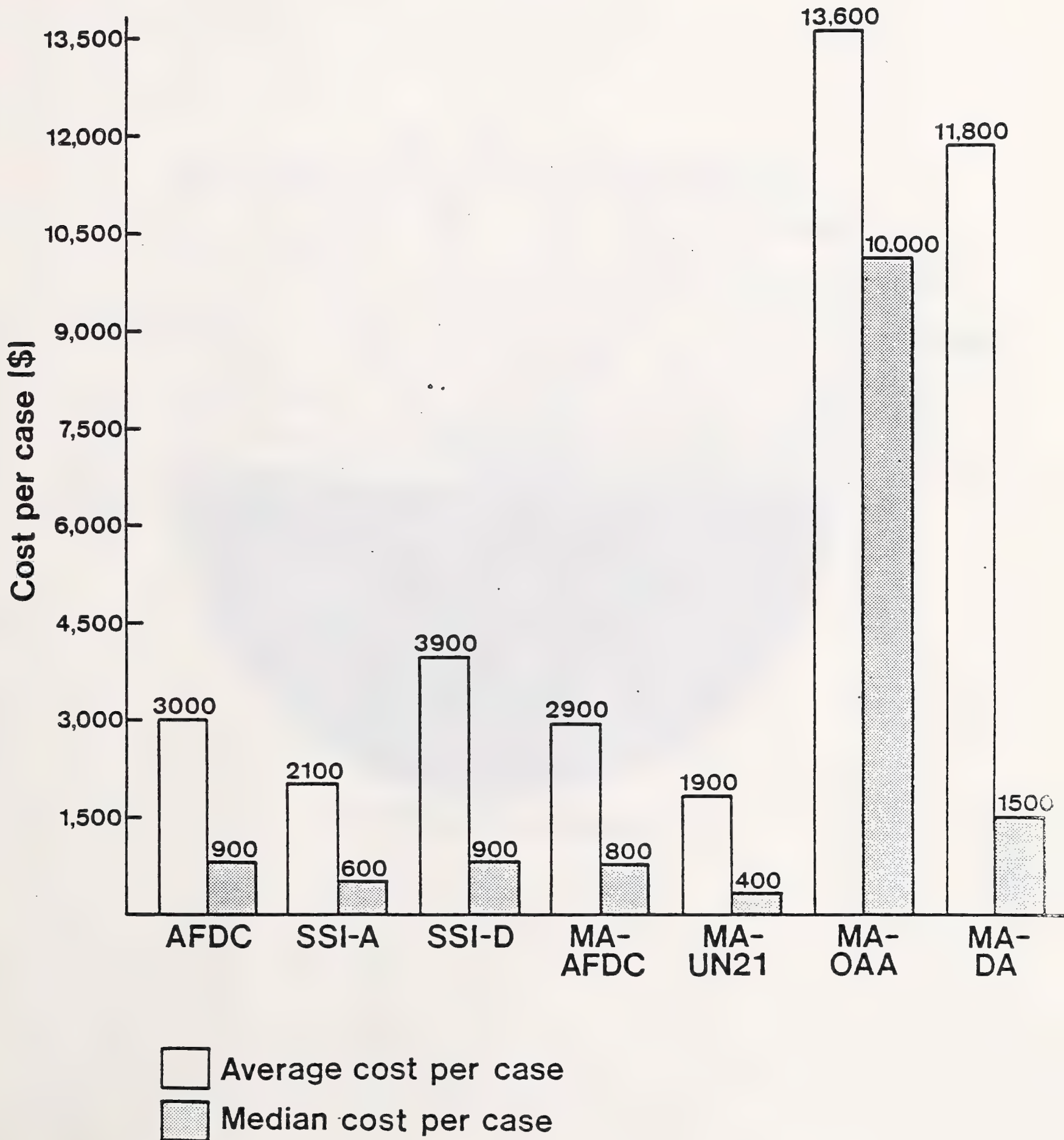
SSI MONTHLY PAYMENT STANDARDS
(Effective 1/1/86)

<u>INDIVIDUAL</u>		<u>Aged</u>	<u>Disabled</u>	<u>Blind</u>
Full Cost of Living	Federal Payment	\$336.00	\$336.00	\$336.00
	State Supplement	128.82	114.39	149.74
	Total Standard	464.82	450.39	485.74
Shared Living Expenses	Federal Payment	\$336.00	\$336.00	\$336.00
	State Supplement	39.26	30.40	149.74
	Total Standard	375.26	366.40	485.74
Household of Another*	Federal Payment	\$224.00	\$224.00	\$224.00
	State Supplement	104.36	87.58	261.74
	Total Standard	328.36	311.58	485.74
Rest Home	Federal Payment	\$336.00	\$336.00	\$336.00
	State Supplement	171.58	171.58	149.74
	Total Standard	507.58	507.58	485.74

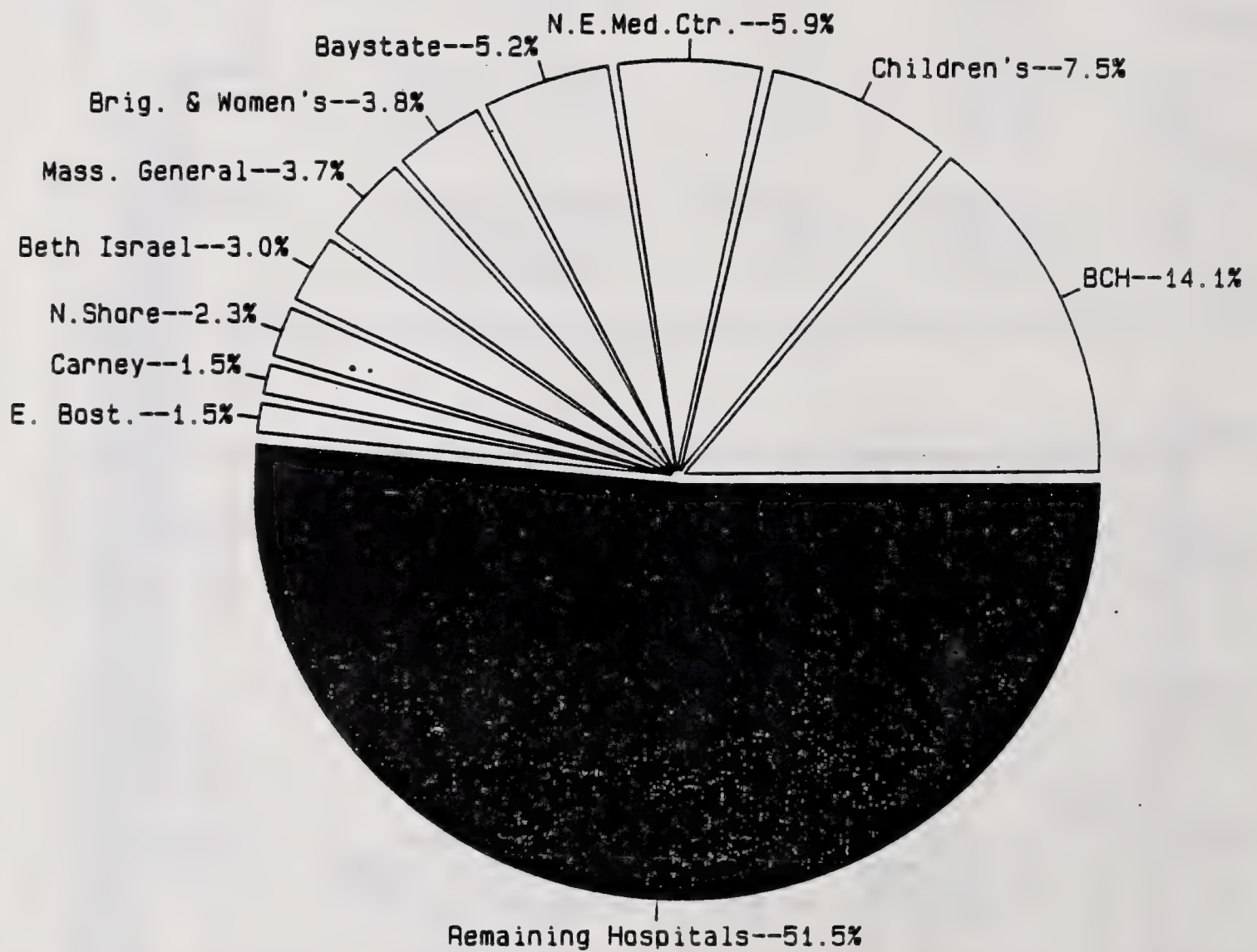
<u>MEMBER OF A COUPLE</u>		<u>Aged</u>	<u>Disabled</u>	<u>Blind</u>
Full Cost of Living	Federal Payment	\$252.00	\$252.00	\$252.00
	State Supplement	100.86	90.03	233.74
	Total Standard	352.86	342.03	485.74
Shared Living Expenses	Federal Payment	\$252.00	\$252.00	\$252.00
	State Supplement	100.86	90.03	233.74
	Total Standard	352.86	342.03	485.74
Household of Another*	Federal Payment	\$168.00	\$168.00	\$168.00
	State Supplement	107.90	97.09	317.74
	Total Standard	275.90	265.09	485.74
Rest Home	Federal Payment	\$252.00	\$252.00	\$252.00
	State Supplement	252.58	252.58	233.74
	Total Standard	504.58	504.58	485.74

* One-third of the federal payment standard is deducted as in-kind income for people in this category. The table shows the payment after this computation.

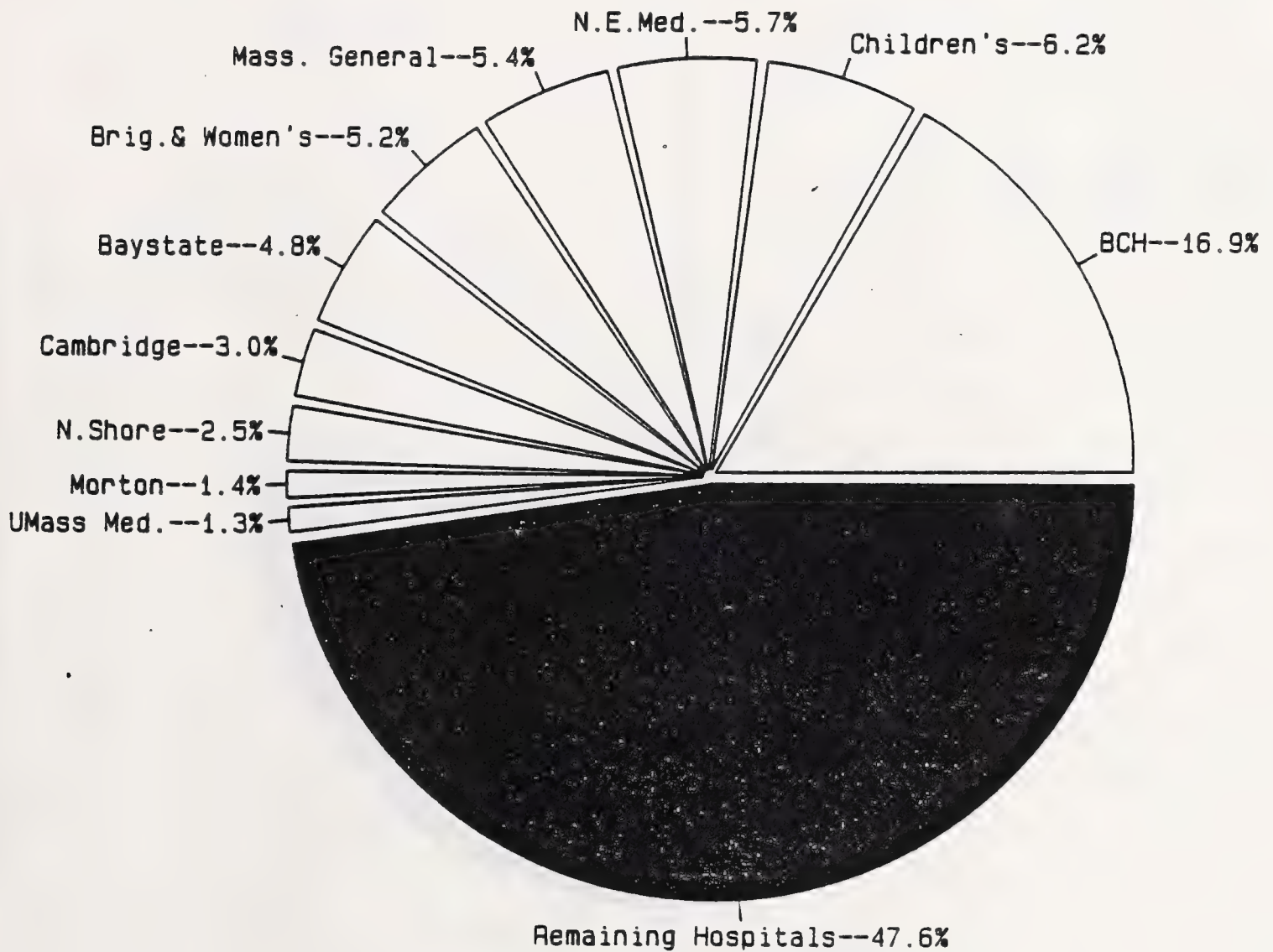
AVERAGE AND MEDIAN COST PER CASE
BY CATEGORY OF ASSISTANCE
FY86



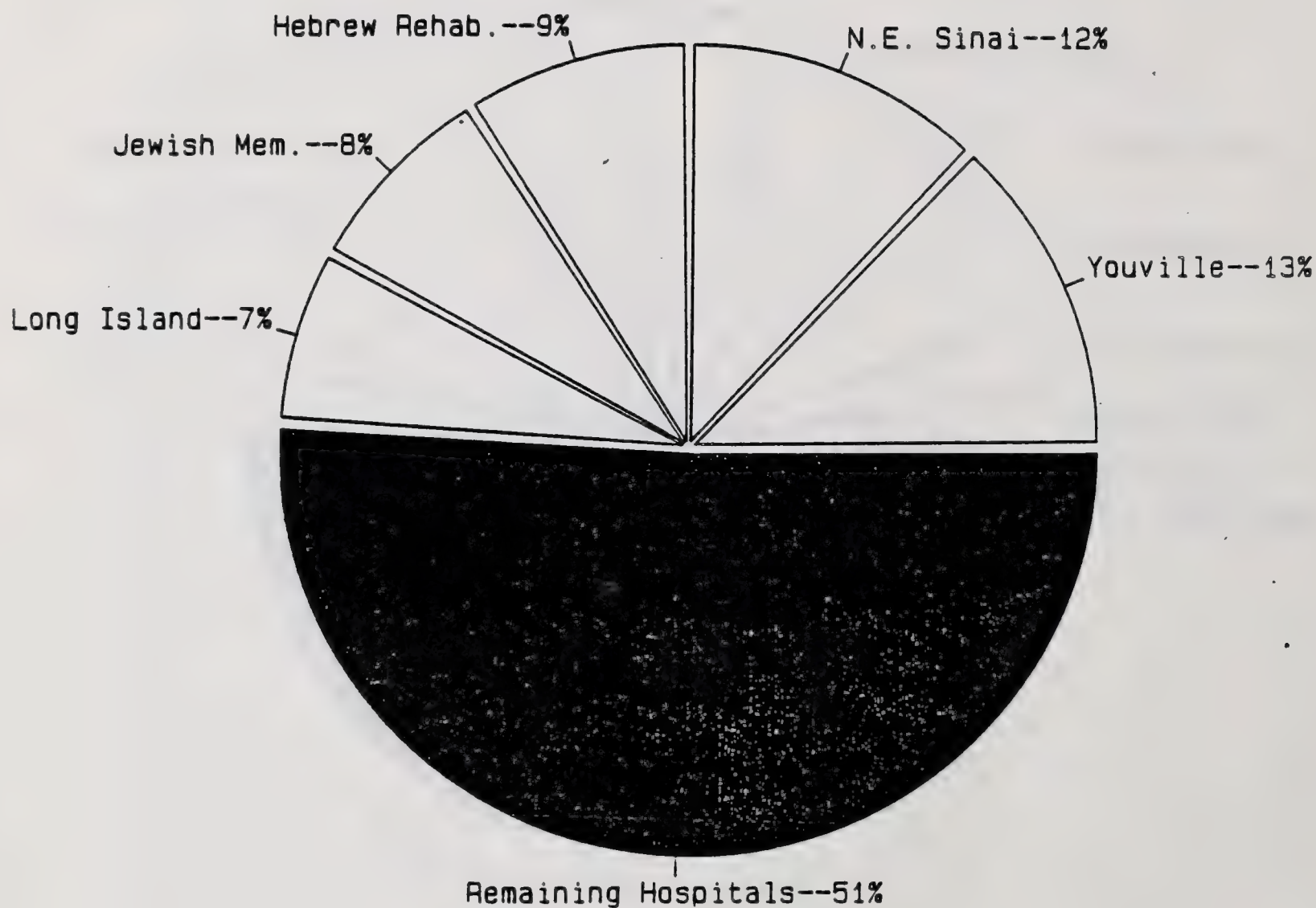
TEN HOSPITALS ACCOUNT FOR
NEARLY HALF OF MEDICAID
OUTPATIENT HOSPITAL SPENDING, FY85



TEN HOSPITALS ACCOUNT FOR
OVER HALF OF MEDICAID
INPATIENT HOSPITAL SPENDING, FY85



FIVE HOSPITALS ACCOUNT FOR
NEARLY HALF OF MEDICAID
CHRONIC HOSPITAL SPENDING, FY85



PROJECT GOOD HEALTH BILLING GUIDE

RECOMMENDED AGE:

X = MUST BE DONE AT THIS AGE

--- MUST BE DONE DURING ONE OF SPANNED AGES

You may claim one PGH visit annually.

You may claim one PGH visit per age interval.

Newborn	2-6 wks	8-10 wks	4 mos	6 mos	9 mos	1 yr	15 mos	2 yrs	30 mos	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10-11 yrs	12-13 yrs	14-15 yrs	16-17 yrs	18-19 yrs	20 yrs
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Screening Procedures

Newborn Initial History and Physical Exam

Newborn Discharge History and Exam

Health or Interval History

Developmental Assessment

Mental and Emotional Assessment

Nutritional Assessment

Health Education and Counseling (As required)

Comprehensive Physical Exam

Pelvic Exam

Hearing (Gross)

Vision (Gross)

Hearing (Audiometry)

Vision (Snellen)

Blood Pressure

Hematocrit/Hemoglobin

EP or Blood Lead

Urinary Dip Stick

Urinalysis

Urine Culture (If indicated)

TB Test

Cholesterol (If history indicates need)

Sickle Cell (if ethnicity indicates need)

Pap Smear

GC Culture

Syphilis/Serology

X

X

X

X

X

X

X

X

X

X

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